SPECIFIC INSTRUCTIONS
for completion of the
2018
NURSING FACILITY (NF) ACCOUNTABILITY REPORT

FOR ASSISTANCE WITH:

Completing the report, contact the Rate Analyst for your program. Contact information is on the Rate Analysis web page at https://rad.hhs.texas.gov/long-term-services-supports/contact-list

Receipt of the report:
HHSC RAD. Phone: (512) 490-3193, E-mail: costinformation@hhsc.state.tx.us

Report Groups assigned to provider's entity:
HHSC RAD. Phone: (512) 490-3193, E-mail: costinformation@hhsc.state.tx.us

Report Preparers or the list of trained Preparers:
HHSC RAD. Phone: (512) 490-3193, E-mail: costinformation@hhsc.state.tx.us

Adding Contacts or problems with your State of Texas Automated Information Reporting System (STAIRS) Username or Password:
Fairbanks, LLC. Phone: (877) 354-3831, E-mail: info@fairbanksllc.com

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TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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Specific Instructions

Welcome to Preparing Accountability reports in the STATE OF TEXAS AUTOMATED INFORMATION REPORTING SYSTEM (STAIRS)

This is the Texas Health and Human Services Commission (HHSC) Rate Analysis Department (RAD) web-based system for long-term care Medicaid cost reporting in the State of Texas: STAIRS. The system is in use for all long-term services and support programs that are required to submit cost reports: the 24 Hour Residential Child Care (24-RCC) program; the Intermediate Care Facility for an Individual with an Intellectual Disability or Related Condition (ICF/IID) program; the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waiver programs; the Nursing Facilities (NF) the Primary Home Care (PHC) and Community Living Assistance and Support Services (CLASS) programs (including both CLASS Case Management Agency (CLASS CMA) and Class Direct Service Agency (CLASS DSA) providers) via the CPC (CLASS/PHC) Cost Report; the Day Activity and Health Services (DAHS) program; and the Residential Care (RC).

For the NF program, most of the accountability reporting processes with which preparers have been familiar when using ACRES has changed. It is very important that you, as a preparer, read these instructions carefully. Here are some of the major changes:

- No paperwork will be mailed – the entire accountability report submission is electronic. All supporting documentation and certification pages will be scanned and uploaded. See APPENDIX A – Uploading Documents into STAIRS. Appendix A includes instructions for those who do not own a scanner. There are also instructions for those wishing to import certain portions of their data directly into STAIRS. See APPENDIX F – Importing Data into STAIRS.

- The system will remember certain types of data from year to year. For these types of data, such as depreciation schedules, you will enter or import the data in this initial year and, in future years, you will only have to verify that nothing has changed, make required changes and/or add new information.

- With only a few exceptions, there will no longer be schedules attached to the accountability report. Information formerly provided on schedules is incorporated in the report itself, with the system doing the calculations and transferring the information to the designated cost items. If a provider does not own property or purchase or lease from or employ related parties, then sections of the accountability report related to those issues will not require entries for that provider's report.

The provider's designated Primary Entity Contact can access STAIRS via the links given in the e-mail notifying them of their login ID and password. If the provider's Primary Entity Contact has not received an e-mail with their login information, they should contact costinformation@hhsc.state.tx.us. Preparers can only access STAIRS if they have been designated as the Preparer by the Primary Entity Contact and have received an e-mail notifying them of their login ID and password for STAIRS. Contacts and preparers who have previously accessed STAIRS for an ICF/IID, HCS/TxHmL, CPC, or other accountability reports, will use the same login ID and password for the NF Accountability report.

ACCOUNTABILITY REPORT TRAINING

All Texas Health and Human Services Commission (HHSC) sponsored accountability report training will be offered via webinar. There will still be separate webinars for new preparers and for those who have taken accountability report training in previous years for each program. Each webinar will include both the general and program-specific content for a program.

Upon completion of the appropriate webinar, preparers will be given the appropriate credit to be qualified to submit an accountability report. Attendees of an Accountability report Training webinar will not receive a certificate as HHSC Rate Analysis will track training attendance internally. Additionally, there will be NO Continuing Education Units (CEUs) or Continuing Professional Education (CPEs) credits for completing a accountability report training webinar.

In order to be able to submit a 2018 accountability report, a preparer must attend the appropriate 2017 or 2018 Cost report Training webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.

PURPOSE

The purpose of the Accountability Report (AR) is to gather information for the Texas Health and Human Services Commission (HHSC) Rate Analysis Department (Rate Analysis) to use in determining compliance with staffing and spending requirements for each facility participating in the Enhanced Direct Care Staff Rate, when a full Texas Nursing Facility Cost Report would not be appropriate.

WHO MUST COMPLETE THIS REPORT?

As described in Title 1 of the Texas Administrative Code (TAC) 355.308(f)(2), facilities that were participants in Rate Enhancement may be required to submit an acceptable AR in certain circumstances, such as a change of ownership, contract terminations, mid-year withdrawal from Rate Enhancement, new participants for a partial year or other reason specified by HHSC Rate Analysis. Providers are notified of their requirement to submit this report in an HHSC Rate Analysis letter that specifically requests this report.

GENERAL

This accountability report is governed by the following rules and instructions:

- Cost Determination Process Rules at Title 1 of the Texas Administrative Code (TAC) §§355.101-355.110;
- Nursing Facility (NF) program-specific rules at 1 TAC §§355.306-355.308 and 355.403;
- The *SPECIFIC INSTRUCTIONS* contained in this document;
- The 2018 Accountability report Training materials.

As stated at 1 TAC §355.105(b)(1), federal tax laws and Internal Revenue Service (IRS) regulations do not necessarily apply in the preparation of Texas Medicaid Accountability reports. Except as otherwise specified in HHSC's Cost Determination Process Rules, accountability reports should be prepared consistent with generally accepted accounting principles (GAAP). Where the Cost Determination Process Rules and/or program-specific rules conflict with IRS, GAAP or other authorities, the Cost Determination Process Rules and program-specific rules take precedence.

In order to properly complete this accountability report, the preparer must:

- Read these instructions;
- Have attended a Cost report Training webinar session and received credit for the 2017 or 2018 Cost report Training sponsored by HHSC. Preparers without the proper training credit will not be able to access the STAIRS data entry application;
- Create a comprehensive reconciliation worksheet to serve as a crosswalk between the facility/contracted provider's accounting records and the accountability report; and
- Create worksheets to explain adjustments to year-end balances due to the application of Medicaid accountability reporting rules and instructions.

DUE DATE AND SUBMISSION (1 TAC §355.105(c))

This report is due at the Rate Analysis Department of the Texas Health and Human Services Commission as specified in the HHSC Rate Analysis letter requesting the AR. You must submit an electronic copy of the report via STAIRS. All information formerly included in schedules is now incorporated into STAIRS; only Schedules D, E, and G remain. Other attachments and signed and notarized certification pages must be uploaded into STAIRS.

Reports will not be considered as "received" until both the electronic and required supporting paper documents are received at HHSC Rate Analysis. See ***APPENDIX A – Uploading Documents into STAIRS***. Documentation mailed rather than uploaded into the system will not be accepted.

WEBSITE

The HHSC RAD website contains program specific accountability report instructions, cost report training information and materials, payment rates, RAD staff contact information and web links for online training, and classroom-based training registration. Additional information and features are added periodically. We encourage you to visit our website at:

https://rad.hhs.texas.gov/long-term-services-supports

FAILURE TO FILE AN ACCEPTABLE ACCOUNTABILITY REPORT (1 TAC §355.105(b)(4)(C)(ii))

According to 1 TAC §355.308(f)(1), failure by a participant in the Enhanced Direct Care Staff Rate to file an AR, completed in accordance with instructions and rules, by the report due date will result in vendor hold. In addition, participating facilities that do not submit an acceptable report within 60 days of the due date will become nonparticipants in the enhancement program retroactive to the first day of the reporting period until they submit an acceptable report and repay funds identified for recoupment.

EXTENSIONS GRANTED ONLY FOR GOOD CAUSE (1 TAC §355.105(c)(3))
Extensions of AR due dates are limited to those requested for good cause. Good cause refers to those extreme circumstances that are beyond the control of the contracted provider and for which adequate advance planning and organization would not have been of any assistance. Submit your written request for an extension at least 15 working days prior to the due date of your AR. The extension request must clearly explain the necessity for the extension and specify the extended due date being requested. Providers who fail to file an acceptable AR by the due date because of the denial of a due date extension are subject to vendor hold.

STANDARDS FOR AN ACCEPTABLE ACCOUNTABILITY REPORT:
To be acceptable, an accountability report must:

1. Be completed in accordance with the Cost Determination Process Rules, program-specific rules, accountability report instructions, and policy clarifications;

2. Be completed for the correct cost-reporting period (Note that the accountability reporting period has been prepopulated. See ***Step 4***. If provider believes that the dates are incorrect, contact HHSC RAD at costinformation@hhsc.state.tx.us for assistance);

3. Be completed using an accrual method of accounting (except for governmental entities required to operate on a cash basis);

4. Be submitted online as a 2018 Accountability report for the correct program through STAIRS;

5. Include any necessary supporting documentation, as required, uploaded into STAIRS;

6. Include signed, notarized, original certification pages (Accountability report Certification and Methodology Certification) scanned and uploaded into STAIRS

7. Calculate all allocation percentages to at least two decimal places (i.e., 25.75%);

8. Have uploaded into STAIRS a property valuation statement(s) from the local taxing authority or an independent appraisal approval letter from HHSC Rate Analysis if required by 1 TAC §355.306(g)(2)(B);

9. Have uploaded into STAIRS a management contract and/or lease agreement, if applicable;

10. If allocated costs are reported, include acceptable allocation summaries, uploaded into STAIRS.

RETURN OF UNACCEPTABLE ACCOUNTABILITY REPORTS (1 TAC §355.106(a)(2))
Failure to complete accountability reports according to instructions and rules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111. Accountability reports that are not completed in accordance with applicable rules and instructions will be returned for correction and resubmission. The return of the accountability report will consist of un-certifying the file originally submitted via STAIRS which will re-open the accountability report to allow additional work and

resubmission by the contracted provider. Notification of the return will be sent through e-mail and certified mail. Failure to resubmit an **acceptable** corrected accountability report by the due date indicated in the return notification will result in recommendation of a vendor hold.

AMENDED ACCOUNTABILITY REPORTS (1 TAC §355.105(d))

Provider-initiated amended accountability reports must be received no more than 60 calendar days after the original accountability report due date. Amended accountability report information that cannot be verified at least 30 calendar days prior to the public hearing on proposed payment rates for the program will not be used in the determination of payment rates.

If, at any time, a provider becomes aware of an error on their accountability report, the provider must contact the Rate Analyst for their program to determine if an amended accountability report is required.

ACCOUNTING METHOD (1 TAC §355.105(b)(1))

All revenues, expenses, and statistical information submitted on accountability reports must be based upon an accrual method of accounting except where otherwise specified in the Cost Determination Process Rules or program-specific reimbursement methodology rules. Governmental entities may report on a cash basis or modified accrual basis. To be allowable on the accountability report, costs must have been accrued during, and paid within 180 days of the end of, the accountability reporting period unless the provider is under bankruptcy protection and has received a written waiver of the 180-day rule from HHSC Rate Analysis.

ACCOUNTABILITY REPORT CERTIFICATION

Contracted providers must certify the accuracy of the accountability report submitted to HHSC. Contracted providers may be liable for civil and/or criminal penalties if the accountability report is not completed according to HHSC requirements or if the information is misrepresented and/or falsified. Before signing the certification pages, carefully read the certification statements to ensure that the signers have complied with the cost-reporting requirements. The Methodology Certification page advises preparers that they may lose the authority to prepare future accountability reports if accountability reports are not prepared in accordance with all applicable rules, instructions, and mandatory training materials.

REPORTING DATA / STATISTICS

Statistical data such as "Hours" must be reported to two decimal places. Please note that the two decimal places are NOT the same as the minutes, but are stated as the percent of an hour. For example, when reporting the hours for Registered Nurses (RN), 150 hours and 30 minutes would be reported as 150.50 hours and 150 hours and 20 minutes would be reported as 150.33 hours.

DIRECT COSTING

Direct costing must be used whenever reasonably possible. Direct costing means that costs incurred for the benefit of, or directly attributable to, a specific business component must be charged directly to that particular business component.

Certain costs are required to be direct-costed, including: medical/health/dental insurance premiums, life insurance premiums, other employee benefits (such as employer-paid disability premiums, employer-paid retirement/pension plan contributions, employer-paid deferred compensation contributions, employer-paid child day care, and accrued leave), direct care staff care staff salaries and wages and direct care staff

contract labor compensation (for direct care staff [e.g. RNs, LVNs, medication aides and certified nurse aides] salaries and contract labor compensation, see ***DEFINITIONS,*** *DIRECT CARE FOR NURSING FACILITIES* for detailed instructions on the reporting of direct care staff time, salaries and wages).

For all direct care staff care and direct care costs, the provider must have documentation that demonstrates the reported costs directly benefited only the program and contracts for which the accountability report is being completed. Daily timesheets documenting time are required for all direct care staff salaries directly charged to the accountability report. If the employee only works for the provider in one program and one position type, the daily timesheet must document the start time, the end time and the total time worked. If the direct care staff works at a different facility under a different provider designation, for a different program of the same provider or in more than one position type (such as NF and Residential Care), there must be daily timesheets to document the actual time spent working for each provider, program or position type so that costs associated with that employee can be properly direct costed to the appropriate cost area.

SPLIT PAYROLL PERIODS

If a payroll period is split such that part of the payroll period falls within the accountability reporting period and part of the payroll period does not fall within the accountability reporting period, the provider has the option of direct costing or allocating the hours and salaries associated with the split payroll period.

For example, if the payroll period covered two weeks, with 6 days included in the cost-reporting period and 8 days not included in the cost-reporting period, the provider could either review their payroll information to properly direct cost the paid hours and salaries for only the 6 days included in the cost-reporting period or the provider could allocate 6/14th of the payroll period's hours and salaries to the accountability report. The method chosen must be consistently applied each cost-reporting period. Any change in the method of allocation used from one reporting period to the next must be fully disclosed as per 1 TAC §355.102(j)(1)(D).

COST ALLOCATION METHODS (1 TAC §355.102(j) and §355.105(b)(2)(B)(v))

Whenever direct costing of shared costs is not reasonable, it is necessary to allocate these costs either individually or as a pool of costs across those business components sharing in the benefits of the shared costs. The allocation method must be a reasonable reflection of the actual business operations of the provider. Contracted providers must use reasonable and acceptable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business components. Allocated costs are adjusted during the audit verification process if the allocation method is unreasonable, is not one of the acceptable methods enumerated in the Cost Determination Process Rules, or has not been approved in writing by HHSC Rate Analysis. An indirect allocation method approved by some other department, program, or governmental entity (including Medicare, other federal funding source or state agency) is not automatically approved by HHSC for cost-reporting purposes. See ***APPENDIX B – Allocation Methodologies*** for details on the types of approved allocation methodologies, when each can be used and when and how to contact HHSC for approval to use an alternate method of allocation other than those approved.

If there is more than one business component, service delivery program, or Medicaid program within the entire related organization, the provider is considered to have central office functions, meaning that administration functions are more than likely shared across various business components, service delivery programs, or Medicaid contracts. Shared administration costs require allocation prior to being reported

as central office costs on the accountability report. The allocation method(s) used must be disclosed as the allocated costs are entered into STAIRS and an allocation summary must be prepared and uploaded to support each allocation calculation.

An adequate allocation summary must include for each allocation calculation: a description of the numerator and denominator that is clear and understandable in words and in numbers, the resulting percentage to at least two decimal places, a listing of the various cost categories to be allocated, 100% of the provider's expenses by cost category, the application of the allocation percentage to each shared cost, the resulting allocated amount, and the accountability report item on which each allocated amount is reported. The description of the numerator and denominator should document the various cost components of each.

For example, the "salaries" allocation method includes salaries/wages and contracted labor (excluding consultants). Therefore, the description of the numerator and the denominator needs to document that both salaries/wages and contracted labor costs were included in the allocation calculations. For the "labor cost" allocation method, the accountability report preparer needs to provide documentation that salaries/wages, payroll taxes, employee benefits, workers' compensation costs, and contracted labor (excluding consultants) were included in the allocation calculations. For the "cost-to-cost" allocation method, the accountability report preparer needs to provide documentation that all allowable facility and operating costs were included in the allocation calculations. For the "total-cost-less-facility-cost" allocation method, the accountability report preparer needs to provide documentation that all facility costs were excluded.

Any allocation method used for cost-reporting purposes must be consistently applied across all contracted programs and business entities in which the contracted provider has an interest (i.e., the entire related organization). If different allocation methods are used for reporting to other funding agencies (e.g., USDA, Medicare, HUD), provide reconciliation worksheets to departmental staff upon request. These reconciliation worksheets must show: 1) that costs have not been charged to more than one funding source; 2) how specific cost categories have been reported differently to each funding source and the reason(s) for such reporting differences; and 3) that the total amount of costs (allowable and unallowable) used for reporting is the same for each report.

Any change in allocation methods for the current year from those used in the previous year must be disclosed on the accountability report and accompanied by a written explanation of the reasons for the change. Allocation methods based upon revenue or revenue streams are not acceptable.

In addition to allocating shared costs between contracted and noncontracted beds and shared administration costs, many NFs have other costs shared between business components. For example, an NF that also provides adult day care services, personal care services, or assisted living services might have shared laundry costs, shared maintenance costs, shared transportation costs, shared dietary costs, shared housekeeping costs, shared security costs, shared administration costs, and other shared costs. Guidelines for allocation of various expenses will be provided in each Step of the *Specific Instructions* as appropriate.

Table 1 below provides a summary of appropriate allocation methods for various situations. If there are any questions regarding proper allocation of shared costs, please contact the Nursing Facility Rate Analyst.

TABLE 1. APPROPRIATE ALLOCATION METHODS FOR REPORTING SHARED ADMINISTRATIVE COSTS THAT CANNOT BE REASONABLY DIRECT COSTED

Makeup of Controlling Entity's Business Components	Multiple Contracts of the Same (Equivalent) Type of Service	Various Business Components - All Labor-Intensive	Various Business Components - All with Programmatic- or Residential-Building Costs	Mixed Business Components - Some with Programmatic- or Residential-Building Costs and Some Labor-Intensive	Shared Administrative Personnel Performing Different Duties for Different Business Components (Not in Direct Care)	Functional Methods
Allowable Allocation Methods	Units of Service	Cost-to-Cost Labor Costs Salaries **Not applicable for nursing facility providers.**	Cost-to-Cost Total-Cost-Less-Facility-Cost Labor Costs Salaries	Total-Cost-Less-Facility-Cost Labor Costs	Time Study*	Payroll Department - Number of payroll checks issued for each business component during the reporting period Purchasing Department - Number of purchase orders processed during the reporting period for each business component

Providers may use any of the methods listed as appropriate for the makeup of their business organization. If one of the approved methods does not provide a reasonable reflection of the provider's actual operations, the provider must use a method that does. If none of the listed methods provides a reasonable reflection of the provider's actual operations, contact the Nursing Facility Rate Analyst for further instructions.

* See 1 TAC §355.105(b)(2)(B)(i) for time study requirements.

RECORDKEEPING (1 TAC §355.105(b)(2)(A) and §355.105(b)(2)(B))

Providers must maintain records that are accurate and sufficiently detailed to support the legal, financial, and statistical information contained in the accountability report. These records must demonstrate the necessity, reasonableness, and relationship of the costs to the provision of resident care, or the relationship of the central office to the individual provider. These records include, but are not limited to, accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, mileage and flight logs, loan documents, insurance policies, asset records, inventory records, organization charts, time studies, functional job descriptions, work papers used in the preparation of the accountability report, trial balances, cost allocation spreadsheets, and minutes of meetings of the board of directors. Adequate documentation for seminars/conferences includes a program brochure describing the seminar or a conference program with a description of the workshop attended. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to contracted-care-related services or quality assurance.

RECORDKEEPING FOR OWNERS AND RELATED PARTIES (1 TAC §355.105(b)(2)(B)(xi))

Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party:

- A detailed written description of actual duties, functions, and responsibilities;
- Documentation substantiating that the services performed are not duplicative of services performed by other employees;
- Timesheets or other documentation verifying the hours and days worked; *(NOTE: this does not mean number of hours, but actual hours of the day);*
- The amount of total compensation paid for these duties, with a breakdown of regular salary, overtime, bonuses, benefits, and other payments;
- Documentation of regular, periodic payments and/or accruals of the compensation;
- Documentation that the compensation was subject to payroll or self-employment taxes; and
- A detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

RETENTION OF RECORDS (1 TAC §355.105(b)(2)(A))

Each provider must maintain records according to the requirements stated in 40 TAC §69.158 (relating to how long contractors, subrecipients, and subcontractors must keep contract-related records).

- The rule states that records must be kept for a minimum of three years and 90 days after the end of the contract period.
- If any litigation, claim, or audit involving these records begins before three years and 90 days expire, the contractor, subrecipient, or subcontractor must keep the records and documents for not less than three years and 90 days or until all litigation, claims, or audit findings are resolved, whichever is longer.

If a contractor is terminating business operations, the contractor must ensure that:

- Records are stored and accessible; and
- Someone is responsible for adequately maintaining the records.

FAILURE TO MAINTAIN RECORDS (1 TAC §355.105(b)(2)(A)(iv))

Failure to maintain all work papers and any other records that support the information submitted on the accountability report relating to all revenue, expense, allocations and statistical information constitutes an administrative contract violation. Procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

ACCESS TO RECORDS (1 TAC §355.106(f)(2) and 1 TAC §355.452(m))

Each provider or its designated agent(s) must allow access to all records necessary to verify information submitted on the accountability report. This requirement includes records pertaining to related-party transactions and other business activities in which the contracted provider is engaged. Failure to allow access to any and all records necessary to verify information submitted to HHSC on accountability reports constitutes an administrative contract violation.

FIELD AUDIT AND DESK REVIEW OF ACCOUNTABILITY REPORTS (1 TAC §355.105(e)-(f) and §355.106)

Each Medicaid accountability report is subject to either a field audit or a desk review by HHSC Accountability report Review Unit (CRRU) Audit staff to ensure the fiscal integrity of the program. Accountability report audits are performed in a manner consistent with generally accepted auditing standards (GAAS), which are included in Government Auditing Standards: Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. These standards are approved by the American Institute of Certified Public Accountants and are issued by the Comptroller General of the United States.

During the course of a field audit or a desk review, the provider must furnish any reasonable documentation requested by HHSC auditors within ten (10) working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or desk review is closed, and HHSC automatically disallows the costs in question, pursuant to 1 TAC §355.105(b)(2)(B)(xviii).

For desk reviews and field audits where the relevant records are located outside the state of Texas, the provider's financial records must be made available to HHSC's auditors within fifteen (15) working days of field audit or desk review notification. Whenever possible, the provider's records should be made available within Texas. When records are not available within Texas, the provider must pay the actual costs for HHSC staff to travel to and review the records located out of state. HHSC must be reimbursed for these costs within 60 days of the request for payment in accordance with 1 TAC §355.105(f).

NOTIFICATION OF EXCLUSIONS AND ADJUSTMENTS (1 TAC §355.107)

HHSC notifies the provider by e-mail of any exclusions and/or adjustments to items on the accountability report. See ***Steps 12-13***. HHSC-OIG furnishes providers with written reports of the results of field audits.

INFORMAL REVIEW OF EXCLUSIONS AND ADJUSTMENTS (1 TAC §355.110)

A provider who disagrees with HHSC's adjustments has a right to request an informal review of the adjustments. Requests for informal reviews must be received by HHSC Rate Analysis within 30 days of the date on the written notification of adjustments, must be signed by an individual legally responsible for the conduct of the interested party and must include a concise statement of the specific actions or determinations the provider disputes, the provider's recommended resolution, and any supporting

documentation the provider deems relevant to the dispute. Failure to meet these requirements may result in the request for informal review being denied.

COMMON ACCOUNTABILITY REPORTING ERRORS

The following is a list of some of the more common errors found on accountability reports. These errors, as well as others, can be avoided by carefully following the accountability report instructions and rules concerning allowable and unallowable expenses.

1. Accountability reports are submitted on a cash basis rather than on an accrual basis of accounting for providers that are not governmental entities.

2. Costs that should be reported separately are combined; for example, the costs incurred for building, vehicle, and general liability insurance are all reported in the same item.

3. Failure to report in ***Step 3*** all state of Texas Medicaid contracts, related entities and/or funding sources to which staff or assets must be allocated.

4. Incorrect related-party staff/contractor information and failure to include an organization chart that clearly identifies each owner-employee, other related-party employee or related-party contractor, along with each business entity/component.

5. Costs are misclassified; for example, the lease expense for a photocopier is incorrectly included in ***Step 8f (FACILITY AND OPERATIONS COSTS, Non-Related Party Facility, Operations, Administrative and Other Direct Care Costs)***, Operations Supplies line instead of being correctly reported in the Rent/Lease – Departmental Equipment/Other line.

6. The number of contracted beds does not agree with the number shown on the current contract.

7. Lease agreements or management contracts are not uploaded in STAIRS (if relevant) or, if uploaded, they are not signed by all parties.

8. Appraised property values are not provided or copies of appraised value statements are not uploaded in STAIRS.

9. Hours and expenses reported in the incorrect staff-type line items.

10. Costs for land are incorrectly included in building historical costs for depreciation purposes.

11. Administrative or other overhead expenses are reported in the Resident Care or Dietary Cost Areas; for example, nurse recruitment costs incorrectly reported as "Other" expenses in the Resident Care Cost Area instead of being reported as an administrative expense.

COMMON ERRORS REGARDING UNALLOWABLE COSTS

1. Expenses are incorrectly reported for activities that are not related to contracted services.

2. Incorrect reporting of personal expenses for items such as personal lunches, personal use of a company vehicle or cellular phone and personal travel expenses not related to employee business travel.

3. Salaries or expenses incorrectly reported for relatives or owners who do not actually work for, or perform services for, the contract.

4. Unallowable promotional advertising incorrectly included in reported advertising costs as an allowable cost.

5. Erroneous reporting as allowable costs those unallowable dues or membership fees to organizations whose primary emphasis is not related to contracted services, for example, Chamber of Commerce, the Lions Club or VFW organizations.

6. Incorrect reporting (with allowable expenses) of unallowable penalties or fines (such as non-sufficient funds (NSF) fees or late payment penalties).

7. Incorrectly expensing bad debts as "Other" costs.

8. Incorrect reporting of payroll taxes. For example, incorrectly reporting FICA/Medicare taxes at greater than 7.65% of the total reported salaries (excluding central office salaries).

9. Erroneously expensing capital expenditures (rather than properly depreciating them) for items such as roofs, air-conditioning systems, vehicles, sidewalks, and paving of the parking lot.

10. Failure to disclose related-party transactions, such as the lease of a building or vehicles.

11. Misstatement of allocated costs because the allocation method used was inappropriate (e.g., based on revenue) or based on unreasonable criteria (e.g., administration salary allocations based on square footage).

12. Overstatement of depreciation costs because land cost was incorrectly included with historical cost of building.

DEFINITIONS

NOTE: For terms not defined in this section, refer to the SPECIFIC INSTRUCTIONS section.

ACCRUAL ACCOUNTING METHOD (1 TAC §355.105(b)(1)) - A method of accounting in which revenues are recorded in the period in which they are earned and expenses are recorded in the period in which they are incurred. If a facility operates on a cash basis, it will be necessary to convert from cash to accrual basis for cost-reporting purposes. Care must be taken to ensure that a proper cutoff of accounts receivable and accounts payable occurred both at the beginning and ending of the reporting period. Amounts earned although not actually received and amounts owed to employees and creditors but not paid should be included in the reporting period in which they were earned or incurred. Allowable expenses properly accrued during the cost-reporting period must be paid within 180 days after the fiscal year end in order to remain allowable costs for cost-reporting purposes, unless the provider is under bankruptcy protection and has obtained a written waiver from HHSC from the 180-day rule in accordance with 1 TAC §355.105(b)(1). If accrued expenses are not paid within 180 days after the fiscal year end and no written exception to the 180-day rule has been approved by HHSC, the cost is unallowable and should not be reported on the accountability report. If the provider's accountability report is submitted before 180 days after the provider's fiscal year end and the provider later determines that some of the accrued costs have not been paid within the required 180-day period, the accountability report preparer should submit a revised accountability report with the unpaid accrued costs removed.

ADMINISTRATION COSTS - the share of all allowable expenses necessary for the general overall operation of the contracted provider's business that is either directly chargeable or properly allocable to this program. Administration costs include office costs and central office costs (i.e., shared administrative costs properly allocated to this program), if applicable. Administration costs are not direct care costs.

ALLOCATION (1 TAC §355.102(j)) - A method of distributing costs on a pro rata basis. For more information, see COST ALLOCATION METHODS in the General Instructions section and the 2018 Accountability report Training materials.

ALLOWABLE COSTS (1 TAC §355.102(a) and §355.103(a)) - Expenses that are reasonable and necessary to provide care to Medicaid recipients and are consistent with federal and state laws and regulations.

AMORTIZATION (1 TAC §355.103(b)(7)) - The periodic reduction of the value of an intangible asset over its useful life or the recovery of the intangible asset's cost over the useful life of the asset. May include amortization of deferred financing charges on the financing or refinancing of the purchase of the building, building improvements, building fixed equipment, leasehold improvements and/or land improvements. The amortization of goodwill is an unallowable cost. The amortization of the purchase price of a Medicaid contract itself (as opposed to the purchase price of the physical facility) is an unallowable cost. For additional information, see *SPECIFIC INSTRUCTIONS* for ***Step 8e*** (***FACILITY AND OPERATIONS COSTS, Depreciation Expense and Related-Party Lease/Purchase of Depreciable Assets)***.

ANCILLARY REVENUES - a separate charge from the routine "daily charge" for room/board that is customarily made or has historically been made for ancillary services. See also definition of ANCILLARY SERVICES.

ANCILLARY SERVICES - certain services provided to residents in addition to routine nursing facility services (e.g., therapies, radiology, and laboratory). See also SPECIFIC INSTRUCTIONS for Schedule G and definition of ROUTINE SERVICES.

APPLIED INCOME - The portion of the daily payment rate paid by the individual in residential programs. The Department of Aging and Disability Services (DADS) determines how much the individual is to pay.

BAD DEBT (1 TAC §355.103(b)(20)(M)) - Unrecoverable revenues due to uncollectible accounts receivable. Bad debts are not reported on the Medicaid accountability report.

BUILDING (FACILITY) COSTS - Costs to be reported as Facility Costs. When allocating shared administrative costs (central office costs) based upon the total-cost-less-facility-cost allocation method, the building (facility) costs to be removed from the cost calculation include Lease/Rental of Building/Facility/Building Equipment; Insurance for those items; Utilities, Maintenance and Contract Services of those items; Mortgage Interest; Ad Valorem Taxes; and Depreciation for Building/Facility/Building Equipment/Land/Leasehold Improvements. Building costs must exclude any goodwill (see definition for *GOODWILL*).

BUSINESS COMPONENT - a separate business entity; a state contract, program, or grant; or an operation separate from the contracted provider's contract that makes up part of the total group of entities related by common ownership or control (i.e., one part of the entire related organization). Each separate contract with the state of Texas is usually considered a separate business component/entity. See also CENTRAL OFFICE.

CENTRAL OFFICE (1 TAC §355.103(b)(7) – Any contracted provider who provides administrative services shared by two or more business components is considered to have a central office. For cost-reporting purposes, a "central office" exists if there are shared administrative functions that require allocation across more than one business. Central office costs are also known as allocated shared administrative costs. The shared administrative functions could be provided by a separate corporation or partnership, or they could be a separate department or separate accounting entity within the contracted entity accounting system. The shared administrative functions could be provided in their own building or co-located with one of the entities for which they provide administrative services (e.g., the shared administrative functions could be provided from spare office space within a programmatic location.)

If an organization consists of two or more contracted entities/business components/service delivery programs that are owned, leased or controlled through any arrangement by the same business entity, that organization probably has administrative costs that benefit more than one of the contracted entities/business components/service delivery programs, requiring that the shared administrative costs be properly allocated across the contracted entities/business components/service delivery programs benefiting from those administrative costs. Typical shared administrative costs may include costs related to the chief executive officer (CEO), chief financial officer (CFO), payroll department, personnel department and any other administrative function that benefits more than one business component. See also the *SPECIFIC INSTRUCTIONS* for Central Office.

CERTIFIED NURSES AIDE – a staff person (employee or contracted) who has completed at least the first 16 hours of classroom nurse aide certification training, since the completion of the first 16 hours of classroom nurse aide certification training allows the staff person to provide direct care services to the residents under nurse supervision. Any time worked before completion of the first 16 hours of classroom nursing aide certification training (i.e., time worked as a hospitality aide) cannot be reported as a nurse aide, but must be reported in item 160 as "Other Resident Care Staff – Nonprofessional".

CHAIN - Contracted entities/business components/service delivery programs that have a common owner or sole member or are managed by a related-party management company are considered a chain. A chain may also include business organizations which are engaged in activities other than the provision of the Medicaid program services in the state of Texas. This means that the business components could be:

- located within or outside of Texas;
- provide services other than the Medicaid services covered by this accountability report, and
- provide services which may or may not be delivered through contracts with the state of Texas.

CHARITY ALLOWANCE - A reduction in normal charges due to the indigence of the resident/participant. This allowance is not a cost since the costs of the services rendered are already included in the contracted provider's costs.

COMBINED ENTITY - one or more commonly owned corporations and/or one or more limited partnerships where the general partner is controlled by the same identical persons as the commonly owned corporation(s). May involve an additional *CONTROLLING ENTITY* which owns all members of the combined entity.

COMMON OWNERSHIP (§355.102(i)(1)) - Exists when an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. If a business entity provides goods or services to the provider and also has common ownership with the provider, the business transactions between the two organizations are considered related-party transactions and must be properly disclosed. Administrative costs shared between entities that have common ownership must be properly allocated and reported as central office costs (i.e., shared administrative costs). See the definition for *RELATED PARTY*.

COMPENSATION, EMPLOYEES (1 TAC §355.103(b)(1)) - Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance.

COMPENSATION, OWNERS AND RELATED PARTIES (1 TAC §355.103(b)(2)) - Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes withdrawals from an owner's capital account; wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance. Allowable compensation must be reported as salaries and not as management fees, unless limits or caps on the

compensation of owners and related parties are stated in the program specific rules, then those limits or caps take precedence.

CONTRACT LABOR – Labor provided by nonstaff individuals. Nonstaff refers to personnel who provide services to the contracted provider intermittently, whose remuneration (i.e., fee or compensation) is not subject to employer payroll tax contributions (e.g., FICA/Medicare, FUTA, or SUTA) and who perform tasks routinely performed by employees. Contract labor does not include consultants. Contract labor hours must be associated with allowable contract labor costs as defined in 1 TAC §355.103(b)(3).

CONTRACT MANAGEMENT - see definition for MANAGEMENT SERVICES.

CONTRACTED BEDS – Licensed beds contracted with Medicaid to provide services to Medicaid residents. These beds can be occupied by Medicaid residents and other residents (e.g., private pay, private insurance, VA). See *SPECIFIC INSTRUCTIONS* for ***Step 5*** (***CONTRACTING ENTITY FINANCIAL DATA***, ***DAYS OF SERVICE AND REVENUE***.

CONTRACTED PROVIDER - see definition for PROVIDER.

CONTRACTED STAFF - See definition for *CONTRACT LABOR*.

CONTRACTING ENTITY - The business component with which Medicaid contracts for the provision of the Medicaid services included on this accountability report. See *SPECIFIC INSTRUCTIONS* for ***Step 4*** (***CONTRACTING ENTITY FINANCIAL DATA, GENERAL INFORMATION).***

CONTRACTUAL ADJUSTMENT – (primarily Medicare) difference between the gross revenue recorded and the amount of reimbursement received which is not paid by any payer source. The amount of revenue reported on the accountability report should be net of all contractual adjustments. Contractual adjustments are not to be reported as Bad Debt and Charity or Courtesy Allowance.

CONTROL (1 TAC §355.102(i)(1) and 1 TAC §355.102(i)(3) - Exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Control includes any kind of control, whether or not it is legally enforceable and however it is exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common.

CONTROLLING ENTITY - The individual or organization that owns the contracting entity. Controlling entity does not refer to provider's contracted management organization.

COURTESY ALLOWANCE - A reduction in normal charges granted as a courtesy to certain individuals, such as physicians or clergy. This allowance is not a cost since the costs of the services rendered are already included in the contracted provider's costs.

CUSTODIAL CARE - see the definition for PERSONAL CARE.

DEPRECIATION EXPENSE (1 TAC §355.103(b)(10)) - The periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. For additional information, see *SPECIFIC INSTRUCTIONS* for ***Step 8e***.

DIRECT CARE (1 TAC §355.308(a)) - resident care provided by nursing personnel (i.e., RNs, LVNs, Medication Aides, Restorative Aides, Certified Nurse Aides), in order to carry out the physician's planned regimen of total resident care. To be allowable as direct care staff, an individual must both meet the appropriate professional certification or licensure requirements and perform nursing-related duties. The actual time (i.e., directly charged time) spent working in one of these positions for the nursing facility must be reported.

Nursing personnel who work performing both nursing facility direct care functions and other functions (e.g., nursing facility administrative functions or any functions for other business components such as a retirement center, residential care center, assisted living component, etc.) must maintain daily, continuous timesheets. The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked (in increments no greater than 30 minutes) performing nursing facility direct care functions and the actual time worked performing other functions. Time must be directly charged and allocation of time is not acceptable in such situations.

The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted licensed nursing facility beds. In such a situation, if the hours and costs cannot be reasonably direct costed in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for distinct reporting, the hours worked and associated costs must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days) and an acceptable allocation summary must be attached.

Staff members who perform more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, restorative aide or certified nurse aide, the staff member is not to be included in the direct care staff cost center. The only exceptions to this rule are respiratory therapists in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments (see "Common Questions/Issues #9). Administrators and assistant administrators are not direct care staff and should not be included in the direct care staff items.

Paid feeding assistants are not included in the direct care staff cost center and are not to be counted toward staffing requirements. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff. Report paid feeding assistants in 6d.

Required documentation of direct care staff hours and compensation includes, but is not limited to, proof of licensure and certification status, time sheets (for staff performing more than one function or working for more than one entity), job descriptions and payroll records.

Common Questions/Issues Regarding the Proper Reporting of Direct Care Staff

1. The following functions are considered direct care functions if performed by a Director of Nurses (DON), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medication Aide, Restorative Aide or Certified Nurses Assistant (CNA): completion of the MDS assessment forms; development of care plans; attendance at direct care training; charting, the nursing administration aspects of a DON's job, and classroom-based direct care training provided by the DON.

2. The following functions are not considered direct care functions: medical records; central supply; someone other than a DON presenting classroom-based direct care training; quality assurance nurse consultant from central office; and time spent filling water pitchers and changing linen by individuals other than RNs, LVNs, Medication Aides, Restorative Aides and CNAs.

3. Does paid time off for direct care staff (e.g., paid vacation, paid sick leave) count as direct care time for this report? Yes, but if it is associated with an individual performing more than one function, it needs to be allocated. If a staff person "cashes in" his/her paid time off instead of taking leave, the time associated with this leave is not to be reported on this report. The compensation received as a result of "cashing in" is treated as a bonus and should be reported in the period in which it is subject to payroll taxes.

4. Pay for being "on-call" is reported as salaries by employee type but only on-call hours actually worked performing direct care functions can be reported as time. For example, if a RN was on call for an entire weekend and received $200 as on-call compensation, the total $200 would be reported as salaries. If the RN was required for three hours to provide assistance to staff while on-call during the weekend, only three hours would be reported as paid hours and not the full 48 hours of the weekend.

5. Graduate Vocational Nurses (GVNs) should be reported as LVNs.

6. Unpaid overtime hours that meet all the other requirements to be reported as direct care staff time may be reported if they are properly documented. Unpaid overtime hours should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours unpaid overtime after the end of her shift, filling in for an absent Medication Aide, the four hours should be reported as RN time. Since the overtime is unpaid, no associated compensation should be reported. Compensation costs may not be imputed for unpaid overtime hours. Volunteer time should not be included on this report.

7. Paid overtime that meets all the other requirements to be reported as direct care staff time may be reported if it is properly documented. Paid overtime hours and compensation should be reported at the highest level of licensure or certification the individual working the overtime possesses.

8. Nurses that are also schedulers, infection control or facility-based quality assurance nurses and CNAs that drive vans must spend at least 50% of their time on direct care functions in order to

report 100% of their paid hours and salaries as direct care. To document the 50+%, the employee should perform a one-month functional time study (i.e., maintain daily timesheets for an entire month). Such a functional study should be completed at least annually. Otherwise, the employee must maintain daily, continuous timesheets to directly charge as direct care only those hours/salaries applicable to direct care functions. Time spent driving a van is not considered direct care time.

9. Respiratory therapists providing direct care in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments may be counted as LVNs.

10. Hours and wages for nurse aides in a Nurse Aide Training and Competency Evaluation Program (NATCEP) can only be reported as direct care if the nurse aide has completed at least the first 16 hours of NATCEP training. Any hours and wages associated with time worked before 16 hours of NATCEP training are completed (e.g. time spent as a hospitality aide or receiving the first 16 hours of NATCEP training) is to be reported as Other Resident Care Staff – Nonprofessional hours and wages in items Step 6d.

DIRECT COST **-** An allowable expense incurred by the provider specifically designed to provide services for this program. If a general ledger account contains costs (including expenses paid with federal funds) attributable to more than one program, the individual entries to that general ledger account which can be specifically "charged" to a program should be charged to that program (i.e., direct costed or directly charged). Those general ledger entries that are shared by one or more programs should be properly allocated between those programs benefited. If an employee performs direct care services for more than one program area (or organization or business component), it will be necessary to direct cost (i.e., directly charge) that employee's costs between programs based upon actual timesheets rather than using an allocation method. If an employee performs both direct care services and administrative services within one or more organizations/business components, it will be necessary to document the portion of that employee's costs applicable to the delivery of direct care services based upon daily timesheets; time studies are not an acceptable method for documenting direct care employees' costs. Direct costs include both salary-related costs (i.e., salaries, payroll taxes, employee benefits, and workers' compensation costs) and nonlabor costs such as the employee's office space costs (e.g., facility costs related to the square footage occupied by the employee's work area) and departmental equipment (e.g., computer, desk, chair, bookcase) used by the employee in the performance of the employee's duties. See definition for *DIRECT COSTING.*.

DIRECT COSTING **-** A method of assigning costs specifically to particular units, divisions, cost centers, departments, business components, or service delivery programs for which the expense was incurred. Costs incurred for a specific entity must be charged to that entity. Costs that must be direct costed include health insurance premiums, life insurance premiums, other employee benefits (e.g., employer-paid disability insurance, employer-paid retirement contributions, and employer-operated child day care for children of employees), and direct care staff salaries and wages. See definition for *DIRECT COST*.

DUALLY CERTIFIED BEDS - beds contracted to provide nursing facility services to Medicaid residents that are also certified for participation in the Medicare program. These are considered contracted beds.

FACILITY COSTS - *See* definition of *BUILDING COSTS.*

GOODWILL – The value of the intangible assets of a business, especially as part of its purchase price. Goodwill is not an allowable cost on the accountability report. See *SPECIFIC INSTRUCTIONS* for ***Step 8*** for instructions on the removal of goodwill.

LEGEND DRUG - (prescription drug) - any drug that requires an order from a practitioner (e.g., physician, dentist, nurse practitioner) before it may be dispensed by a pharmacist, or any drug that may be delivered to a resident by a practitioner in the course of the practitioner's practice.

MANAGER - a person, other than a licensed nursing home administrator, having a contractual relationship to provide management services to a contracted nursing facility provider. If the contracted manager and the provider are related by common ownership or control, the related party management costs must be reported as central office costs (Step 6e).

MANAGEMENT SERVICES (1 TAC §355.103(b)(6)) - Services provided under contract between the contracted provider and a person or organization to provide for the operation of the contracted provider, including administration, staffing, maintenance, or delivery of resident/participant care services. Management services do not include contracts solely for maintenance, laundry, or food service. If the provider contracts with another entity for the management or operation of the program, the provider must report the specific direct services costs of that entity and not the amount for which the provider is contracting for the entity's services. Expenses for management provided by the contracted provider's central office must be reported as central office costs.

MEDICAID-ONLY RESIDENTS - residents who are eligible recipients of Medicaid nursing facility vendor payments and who ARE NOT ELIGIBLE for payments for ancillary services from other sources (such as Medicare or private insurance).

NECESSARY (1 TAC 355.102(f)(2)) - Refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing care for individuals in accordance with the contract and state and federal regulations. See TAC reference for additional requirements.

NET EXPENSES (1 TAC §355.102(k) and 1 TAC §355.103(b)(18)(D)) - Gross expenses less any purchase discounts or returns and purchase allowances. Only net expenses should be reported on the accountability report.

NON-CONTRACTED BEDS – Licensed nursing beds that are not contracted to provide nursing facility services to Medicaid residents. Medicare-only or private pay residents may occupy these licensed beds. Beds licensed as personal care beds are not non-contracted beds; no statistics, revenues, or costs related to personal care beds should be reported on a Medicaid accountability report.

NON-MEDICAID RESIDENTS - Non-Medicaid residents include, but are not limited to, private pay, private insurance, Veterans Administration, Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB) and Dual Eligible (Medicare/Medicaid) residents.

NON-PARTICIPATING BEDS - licensed nursing beds that are not contracted with Medicaid or Medicare.

OWNER - an individual or organization that possesses any ownership or equity in a business entity. A person who is a sole proprietor, partner, limited liability company member, or corporate stockholder owning any of the outstanding stock of the contracted provider is considered an owner, regardless of the percentage of ownership. For an owner-employee, only an owner-employee who is also a sole proprietor, a partner owning 5% or more of the partnership, a limited liability company member, or corporate stockholder owning 5% or more of the outstanding stock of the corporation is required to be claimed on the accountability report.

PERSONAL CARE - (sometimes referred to as "custodial care" or "assisted living") services primarily for the purpose of helping with the activities of daily living (such as eating, dressing, grooming, bathing, toileting, transferring, ambulating, mobility or assistance with or self-administration of medications). Personal care services do not include nursing services.

PERSONAL CARE BEDS – Beds not licensed by the Department of Aging and Disability Services (DADS) as nursing beds or beds licensed by DADS as personal care beds (and not as nursing beds). Personal care beds are not noncontracted nursing beds; no statistics, revenues, or costs related to personal care beds should be reported on a nursing facility accountability report.

PROVIDER - the individual or legal business entity that is contractually responsible for providing Medicaid services, i.e., the business component with which Medicaid contracts for the provision of nursing facility services. Also known as contracted provider. See definition for CONTRACTING ENTITY.

PURCHASE DISCOUNTS (1 TAC §355.102(k)) - Discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity, and cash discounts. Trade discounts result from the type of purchaser the contracted provider is (i.e., consumer, retailer, or wholesaler). Quantity discounts result from quantity purchasing. Cash discounts are reductions in purchase prices resulting from prompt payment. Reported costs must be reduced by these discounts prior to being reported on the accountability report.

PURCHASE RETURNS AND ALLOWANCES (1 TAC §355.102(k)) - Reductions in expenses resulting from returned merchandise or merchandise that is damaged, lost, or incorrectly billed. Reported expenses must be reduced by these returns and allowances prior to being reported on the accountability report.

REASONABLE (1 TAC 355.102(f)(1) - Refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service. See TAC reference for additional considerations in determining reasonableness.

REFUNDS AND ALLOWANCES - Reductions in revenue resulting from overcharges.

REIMBURSEMENT METHODOLOGY (1 TAC §§355.306-308 and §355.403) - Rules by which HHSC determines daily payment rates for nursing facility services that are statewide and uniform by class of service.

RELATED PARTY (1 TAC §355.102(i)) - A person or organization related to the contracted provider by blood/marriage, common ownership, or any association, which permits either entity to exert power or influence, either directly or indirectly, over the other. In determining whether a related-party relationship exists with the contracted provider, the tests of common ownership and control are applied separately. Control exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for cost-reporting purposes: (1) husband and wife; (2) natural parent, child and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepsister, and stepbrother; (5) father-in-law, mother-in-law, brother-in-law, son-in-law, sister-in-law, and daughter-in-law; (6) grandparent and grandchild; (7) uncles and aunts by blood or marriage; (8) first cousins, and (9) nephews and nieces by blood or marriage. Disclosure of related-party information is required for all allowable costs reported by the contracted provider. ***Step 6*** (CONTRACTING ENTITY ***FINANCIAL DATA***, ***WAGES AND COMPENSATION)*** and ***Step 8*** of STAIRS both have substeps designed for reporting compensation of related parties (both wage and contract compensation) and related-party transactions, including the purchase/lease of equipment, facilities, or supplies, and the purchase of services including related-party loans (i.e., lending services). See also definitions of *COMMON OWNERSHIP*, *CONTROL*, *RELATED*, and *RELATED-PARTY TRANSACTIONS*. See also the Accountability report Training materials.

RELATED PARTY TRANSACTIONS (1 TAC §355.102(i)) – The purchase/lease of facilities, services, equipment, or supplies from the contracted provider's central office, an individual related to the provider by common ownership or control, or an organization related to the provider by common ownership or control. Allowable expenses in related party transactions are reported on the accountability report at the cost to the related party. However, such costs must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased/leased elsewhere in an arm's-length transaction.

RESIDENT – Any individual residing in a residential Medicaid program facility.

RESIDENT DAY – Services for one resident for one day. The day the resident is admitted is counted as a day of service. The day the resident is discharged is not counted as a day of service. A resident day is also known as a day of service and is the unit of service for the nursing facility program.

REVENUE REFUNDS – Reductions in revenue resulting from overcharges.

ROUTINE SERVICES – sometimes referred to as the "room-and-board" charge for nursing facility services. Included in routine services are regular room, dietary and nursing services, minor medical and nursing supplies and certain equipment and facilities. Ancillary services are **not** routine services (see definition of ANCILLARY SERVICES). Refer to 40 TAC §19.2601, Vendor Payment (Items and Services Included) for a complete listing of routine services.

SAFETY PROGRAM – An ongoing, well-defined program for the reduction/prevention of employee injuries. The costs to administer such a program may include the development/purchase and maintenance of a training program and safety officer/consultant costs. Salaries and wages for staff administering the safety program must be based upon the hours worked on the safety program (from

actual timesheets or time studies). These safety program costs should be reported as ADMINISTRATION COSTS.

SELF INSURANCE (1 TAC §355.103(b)(13)(b)) - See ***APPENDIX E – Self-Insurance.***

STARTUP COSTS (1 TAC §355.103(b)(20)(D)) – Those reasonable and necessary preparation costs incurred by a provider in the period of developing the provider's ability to deliver services. Startup costs can be incurred prior to the beginning of a newly formed business and/or prior to the beginning of a new contract or program for an existing business. Allowable startup costs include, but are not limited to, employee salaries, utilities, rent, insurance, employee training costs, and any other allowable costs incident to the startup period. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation as described in the Cost Determination Process Rules. Any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from startup costs. Allowable startup costs should be amortized over a period of not less than 60 consecutive months. If the business component or corporation never commences actual operations, or if the new contract/program never delivers services, the startup costs are unallowable.

VENDOR HOLD – HHSC rules specify payments may be withheld from contracted providers in certain specific situations, as described in 1 TAC §355.403, §355.308, and §355.111.

WORKERS' COMPENSATION COSTS – For cost-reporting purposes, the costs accrued for workers' compensation coverage (such as commercial insurance premiums and/or the medical bills paid on behalf of an injured employee) are allowable. Costs to administer a safety program for the reduction/prevention of employee injuries are not workers' compensation costs; rather, these costs should be reported as ADMINISTRATION COSTS. See definition of *SAFETY PROGRAM*.

SPECIFIC INSTRUCTIONS

GENERAL SYSTEM NAVIGATION

Add Record – Used to add lines to the current category. It may be used to add an initial entry to the category or to add Allocation detail to an initial entry. If more lines are needed than initially appear, enter information for the initially appearing lines, Save, and click Add Record again for more lines.

Edit Record – Click the button beside the record to be edited before clicking this box. This will allow the user to change any specifics previously added to this record.

Delete Record – Click the button beside the record to be deleted before clicking this box. This will delete the selected record.

Save – Used to save the current data. Will save the information in the current location and allow additional Add, Edit or Delete actions.

Save and Return – Saves the current data and returns to the prior level screen.

Cancel – Cancels all unsaved information on the current screen and returns user to the prior level screen.

Stop Signs – A stop sign appears when an action needs to be taken by the preparer in order to either continue or before finalizing the accountability report. They will variously tell the preparer that an action must be taken prior to being able to "Save" information in the current screen, that an edit must be responded to before the report can be finalized, or that a required piece of information is needed on the current screen.

USER INTERFACE AND DASHBOARD

The initial screen a STAIRS user will see upon logging into the system is the Dashboard. From there the user can see and edit their personal contact information, to include e-mail, address and telephone and fax numbers. Also on this Dashboard page are important information messages and listings of important dates and upcoming training opportunities. Training registration can be accessed from this page.

By clicking on "Manage" to the right on the top bar, the user can, depending on his or her permissions, add a contact, attach a person to a role or assign a preparer.

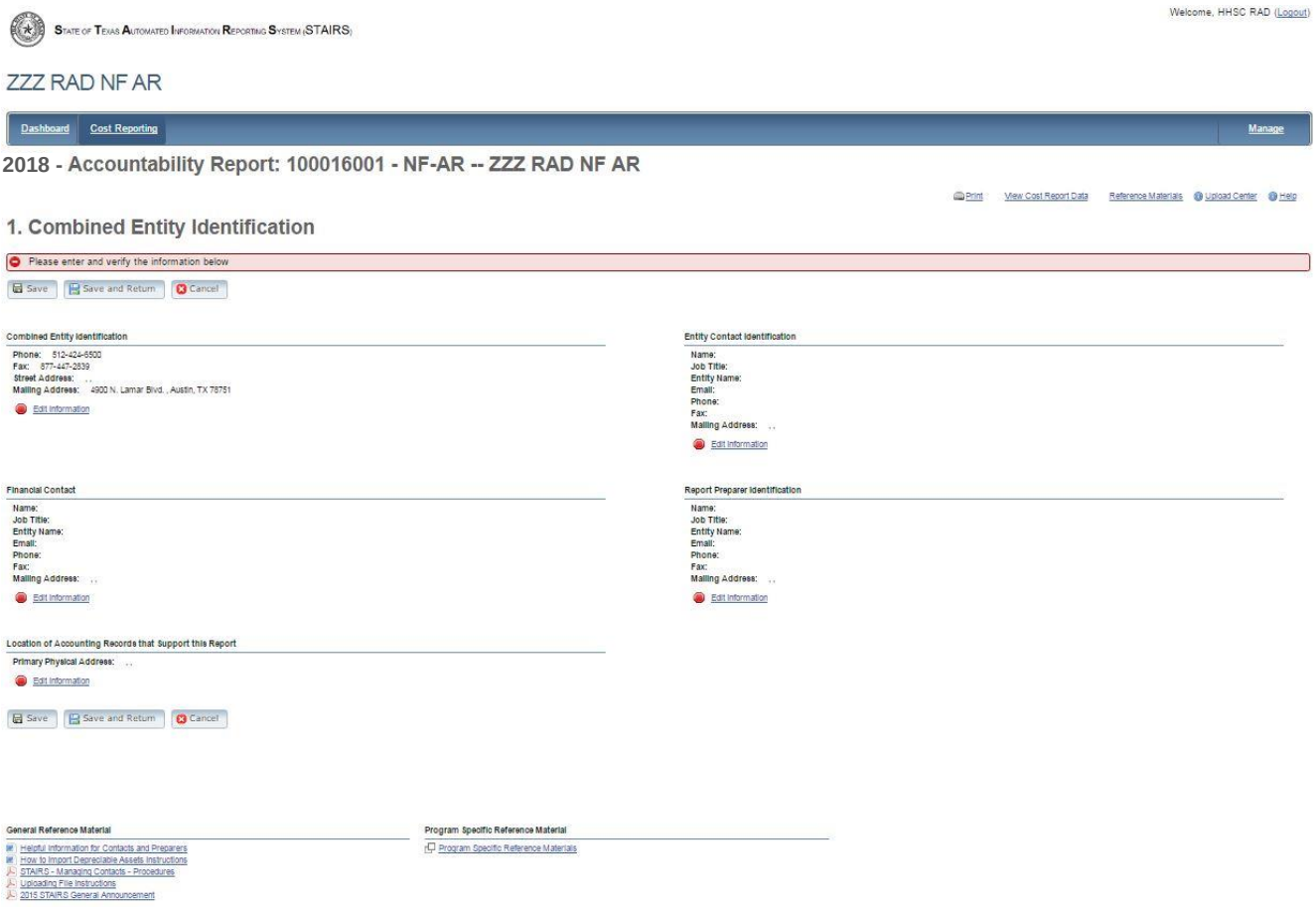
The document titled "Managing Contacts Processing Procedures" gives detailed instructions for managing contacts, including understanding roles and what can be done within the system by persons assigned to the various roles. This document is located in the Reference Materials section located at the bottom of all STAIRS pages.

The Upload Center is also located under "Manage".

Once the user is in the system, they can click on "Accountability reporting" on the top bar. If the user has access permission for only a single contract number and program, for example Contract Number 001234567 for Nursing Facility (NF), then there will only be one option to click on the initial Accountability reporting page. If the user has access permission for more than one contract number and/or program, for example Contract Number 001234567 for NF and Contract Number 001234568 for Residential Care, then the user will need to choose the contract number and report in which the user wishes to work.

COMBINED ENTITY DATA

Step 1 COMBINED ENTITY IDENTIFICATION



Combined Entity Identification

In this section the provider may update telephone, e-mail and address information for the combined entity. If this is a single provider entity with no combined entities, this will be the information for the contracted provider as well.

Entity Contact Identification

In this section, the provider may update the information on the contact person. The contact person must be an employee of the controlling entity, parent company, sole member, governmental body, or related-party management company (i.e., the entire related organization) who is designated to be contacted concerning information reported on the accountability report. The contact person should be able to answer questions about the contents of the provider's accountability report.

Financial Contact

A primary contact may designate a Financial Contact. This person can review the accountability report, but may not make entries into the system.

Report Preparer Identification

In accordance with 1 TAC §355.102(d), it is the responsibility of each provider to ensure that each accountability report preparer who signs the Accountability report Methodology Certification completes the required HHSC-sponsored accountability report training. The STAIRS accountability reporting application will identify whether the person designated as a preparer has completed the required training. Only a preparer who has attended the 2017 or 2018 cost report training webinar from HHSC will be able to complete an accountability report in STAIRS. A list of preparers who have completed the training may be accessed through the Rate Analysis website (see the WEBSITE section of the General Instructions) by scrolling down to the "Training Information" heading and clicking on "Accountability reports", then "Mandatory Accountability report Training" and then "Preparer List."

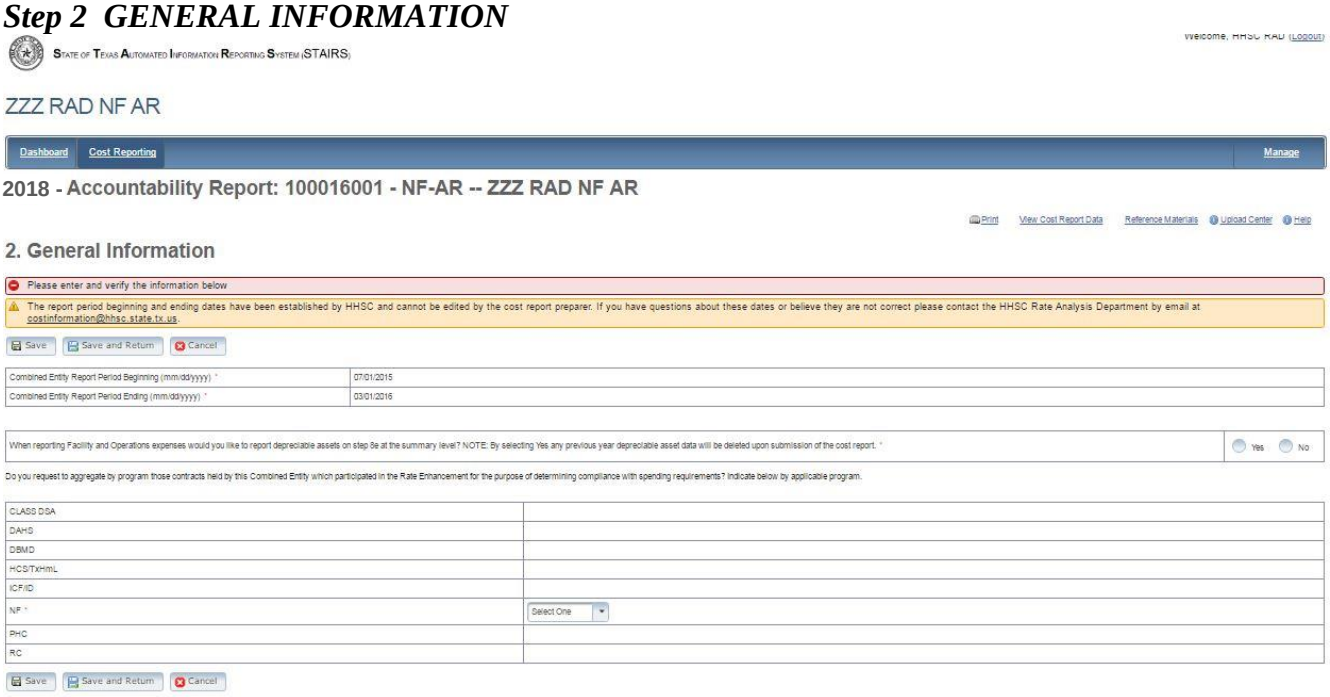
Preparers must complete accountability report training for every program for which a accountability report is submitted. Such training is required every other year for the odd-year accountability report in order for the preparer to be qualified to complete both that odd-year accountability report and the following even-year accountability report. To sign as preparer of a 2018 accountability report for a specific program, the preparer must have attended the webinar training for that program's 2017 or 2018 cost report.

Accountability report preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of accountability report preparation. NO EXEMPTIONS from the accountability report training requirements will be granted.

Location of Accounting Records that Support this Report

Enter the address where the provider's accounting records and supporting documentation used to prepare the accountability report are maintained. This should be the address at which a field audit of these records can be conducted. These records do not refer solely to the work papers used by the provider's CPA or other outside accountability report preparer. All working papers used in the preparation of the accountability report must be maintained in accordance with 1 TAC 355.105(b)(2)(ii). (See also the RECORDKEEPING section of the General Instructions.)

Step 2 GENERAL INFORMATION



Combined Entity Reporting Period Beginning and Ending Dates:
These dates represent the beginning and ending dates for the combined entity's reporting period. If this is a single provider entity with no combined entities, the information for the contracted provider will be used as that of the combined entity. For a combined entity that submitted a cost report in a prior year, these dates will be based on the dates from the prior cost report. For a combined entity that is reporting for the first time this year, the dates are based on the contract beginning date and the assumption that the provider is on a calendar fiscal year, so has an ending date of 12/31 of the cost report year. If these dates are not correct, contact HHSC RAD at costinformation@hhsc.state.tx.us for assistance. Failure to assure that the reporting period is correctly identified will result in the accountability report being returned and all work previously done on the report being deleted from the system.

This reporting period for an Accountability Report will be specified by the Rate Analysis Department when the report is requested. This date span must match DADS records regarding the effective dates of the combined entity's current contract(s). If there is a discrepancy, the accountability report will be rejected as unacceptable and returned for proper completion.

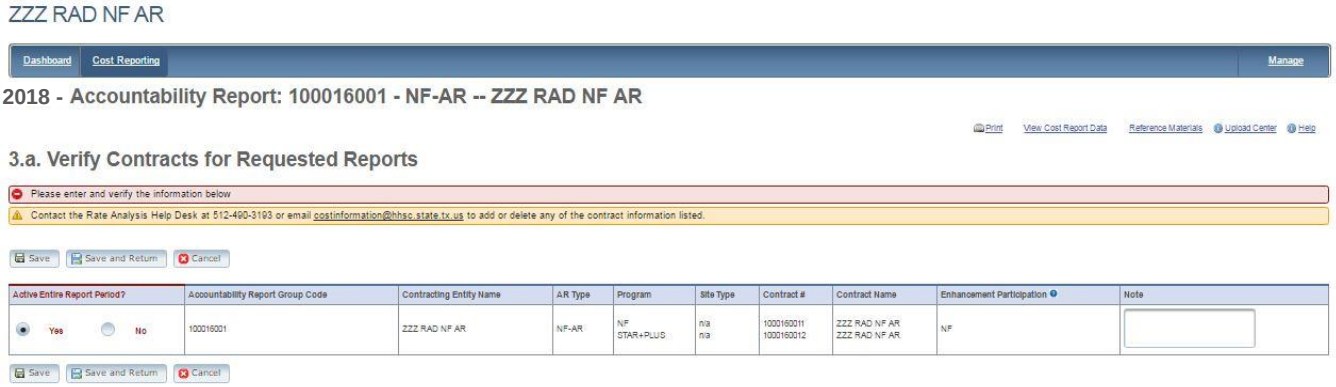
Do you request to aggregate by program those contracts held by this Combined Entity that participate in the Direct Care Staff Compensation Rate Enhancement for the purpose of determining compliance with spending requirements?
If an entity operates two or more NF contracts that participate in the Direct Care Staff Compensation Rate Enhancement program, they may choose to have this group of contracts reviewed in the aggregate for the purposes of determining compliance with spending requirements.

Additionally, if an entity operates two or more contracts and/or component codes that participate in the Attendant Compensation Rate Enhancement program, they may choose to have this group of contracts by

program reviewed in the aggregate for the purposes of determining compliance with spending requirements.

Step 3 CONTACT MANAGEMENT

Step 3a Verify Existing DADS Contract Numbers:



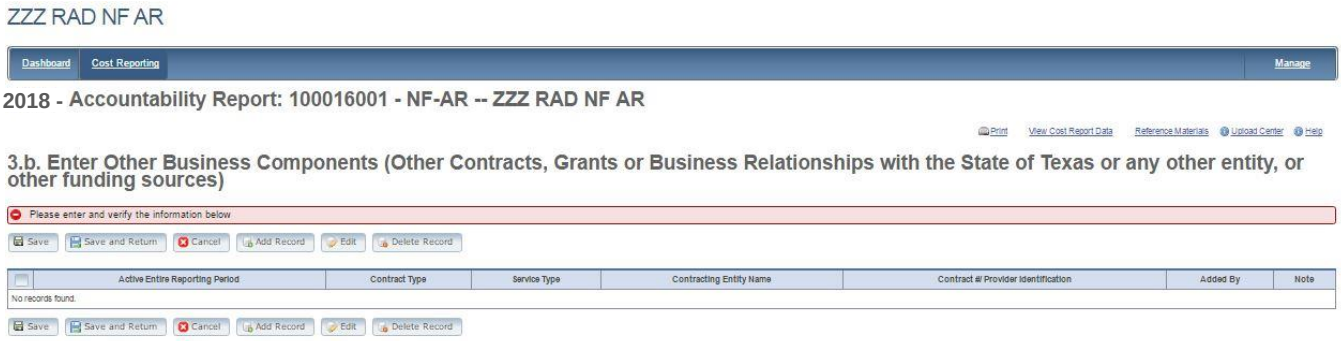
This list carries over from year to year. It is a list of all NF program contracts operated by the provider's combined entity grouped by Cost report Group Codes. For each cost report group, the preparer must indicate in the left-most column whether the contracts in the cost report Group were active during the entire accountability report period. If the answer to this question for a specific component code/contract is "No", then an explanation must be entered in the Note column.

If the preparer believes that one or more additional contracts should be added to the prepopulated list or that a contract included in the prepopulated list should be deleted, contact HHSC RAD at costinformation@hhsc.state.tx.us for assistance. Providers cannot add to or delete from this list independently. Failure to correctly verify this list may result in all STAIRS accountability reports for the combined entity being returned as unacceptable.

Step 3b Enter Other Contracts, Grants or Business Relationships with the State of Texas or with any other Entity:

This list carries over from year to year. It is a list of all Texas and out-of-state business relationships in which the combined entity is involved. For each contract, grant or business, the preparer must indicate in the left-most column whether the contract, grant or business was active during the entire accountability report period. If the answer to this question for a specific contract, grant or business relationship is "No", then an explanation must be entered in the Note column.

A preparer can add, edit or delete items from this list. Clicking Add will lead to the Add Contracts screen where all the necessary information can be added. See graphic below. Any changes to this list will trigger changes to the accountability report(s) for any other contracts controlled by the provider's combined entity. If these other accountability reports are being completed by a different preparer who has verified Steps involving allocation, STAIRS will automatically unverify those Steps in those reports. The other preparer will need to address those Steps again prior to completing those reports.

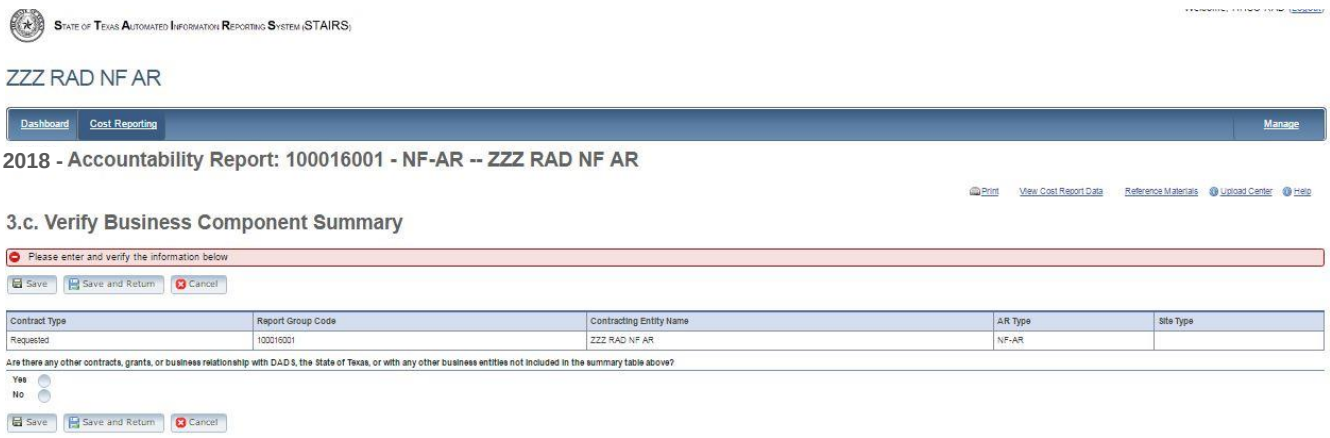


Information necessary to add an additional contract includes

A. Was the contract active during the entire accountability report period? – If "No" is chosen, provider will be required to enter an explanation in the Notes section.
B. Contract Type – The contract type will drive available options in Service Type below. Contracts which are neither state nor Medicare will be designated as "Other".
C. Service Type – The service type menu is driven by the Contract Type above. If the service type is not listed, the preparer should choose "Other". If the preparer chooses "Other", a box will appear for entry of the type of other contract.
D. Contract # / Provider Identification – The contract number or other identifying information regarding the contract. For contracts that don't have state or federal contracting numbers, this may be the legal name of the related organization with which the provider is contracting.

To Edit or Delete a contract, select it by clicking the round button to the far left beside that contract. Then choose an action, either Edit Record or Delete Record.

Step 3c Verify Contract Summary:

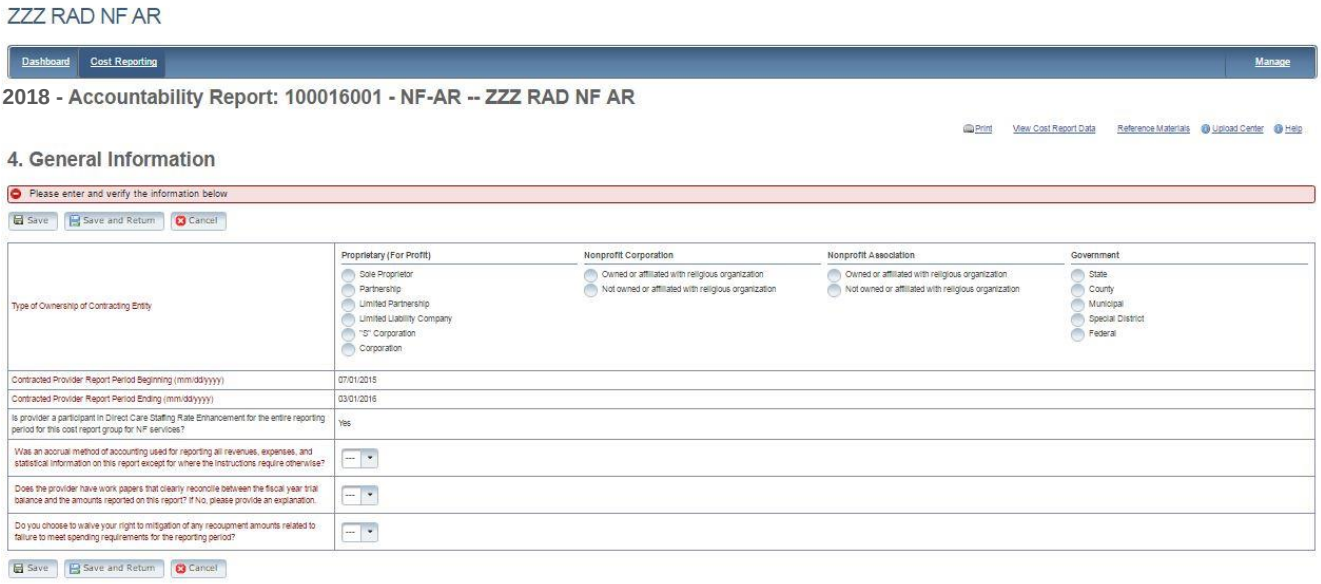


This screen lists all contracts, grants and business entities contained in ***Steps 3a and 3b*** above. Preparers must answer the question at the bottom of the page in order to clear the Stop Sign for this Step. The question "Are there any other contracts, grants, or business relationship with DADS, the State of Texas, or with any other business entities not included in the summary table above?" must be answered either "Yes" or "No". An answer of "Yes" will take the preparer to ***Step 3b*** above.

CONTRACTING ENTITY FINANCIAL DATA

Step 4 GENERAL INFORMATION

From this point forward in the instructions, all requested information must be reported based only on the contracting entity and program for which the accountability report is being prepared.



Type of Ownership of Contracting Entity:
Identify the type of ownership of the provider contracting entity from the list. Note: If the provider is a for-profit corporation or one segment of a for-profit corporation (e.g. a dba of a for-profit corporation), "Corporation" is the appropriate entry.

Contracted Provider Reporting Period Beginning and Ending Dates:
The reporting period beginning date cannot be earlier than January 1, 2017. If your contract is new between January 1, 2016 and December 31, 2017, your beginning date is the effective date the facility became participants in the Enhanced Direct Care Staff Rate Program. If your contract was acquired through a change of ownership between January 1, 2017 and December 31, 2018, your beginning date is the initial date of your contract.

If the provider's contract is new or was acquired during the 2017 reporting period, complete the accountability report for the period beginning with the initial date of the provider's first contract and

ending with the last day of the last month of the provider's fiscal year ending in 2017. Refer to 1 TAC §355.105(b)(5) for additional information on the cost-reporting year.

If the provider's reporting period is less than twelve months, the accountability report preparer must properly report only those statistics, revenues and expenses associated with the reporting period. For example, if the provider's reporting period was 2/1/17 through 12/31/17, it is unacceptable for the accountability report preparer to report 11/12 of the provider's annual days of service, annual revenues, and annual expenses. Instead, the accountability report preparer should only report information related to the reporting period, meaning that days of service, revenues, and costs related to the month of January 2016 are not to be included anywhere on the accountability report.

If the reporting period does not begin on the first day of a calendar month or end on the last day of a calendar month, it is imperative that the accountability report preparer properly report only those statistics (i.e., days of service), revenues, and costs associated with the actual cost-reporting period. If, for example, the provider's cost-reporting period was 8/15/17 through 12/31/17, it is unacceptable for the accountability report preparer to report 37.8% of the provider's total days of service, revenues, and costs for the year. Rather, the accountability report preparer must report the days of service, revenues and costs associated only with the period 8/15/17 through 12/31/17. Since the month of August is partially reported (i.e., 8/15 - 8/31), the accountability report preparer will have to calculate 17/31 of various costs applicable to the month of August (e.g., building rent/depreciation, August utilities, and other such "monthly" costs) and include that with the actual costs for September - December. For questions regarding the appropriate method for reporting information for less than a full year, please contact the Rate Analyst.

Is provider a participant in Direct Care Staff Compensation Rate Enhancement for Nursing Facility Services?

This answer will be prepopulated and based on whether the provider was a participant for the entire accountability reporting period. If the prepopulated answer appears to be incorrect, please contact the Rate Analyst.

Was an accrual method of accounting used for reporting all revenues, expenses and statistical information on this report, except for where instructions require otherwise?

Click either "Yes" or "No". If "No", provide a reason in the Explanation Box. For the definition of the accrual method of accounting, see the **DEFINITIONS** section. An accrual method of accounting must be used in reporting information on Texas Medicaid accountability reports in all areas except those in which instructions or cost-reporting rules specify otherwise. Accountability reports submitted using a method of accounting other than accrual will be returned to the provider, unless the provider is a governmental entity (i.e., Type of Ownership is in the Government column) using the cash method or modified accrual method. Refer to 1 TAC §355.105(b)(1) for additional information on accounting methods.

Does the provider have work papers that clearly reconcile between the fiscal year trial balance and the amounts reported on this report?

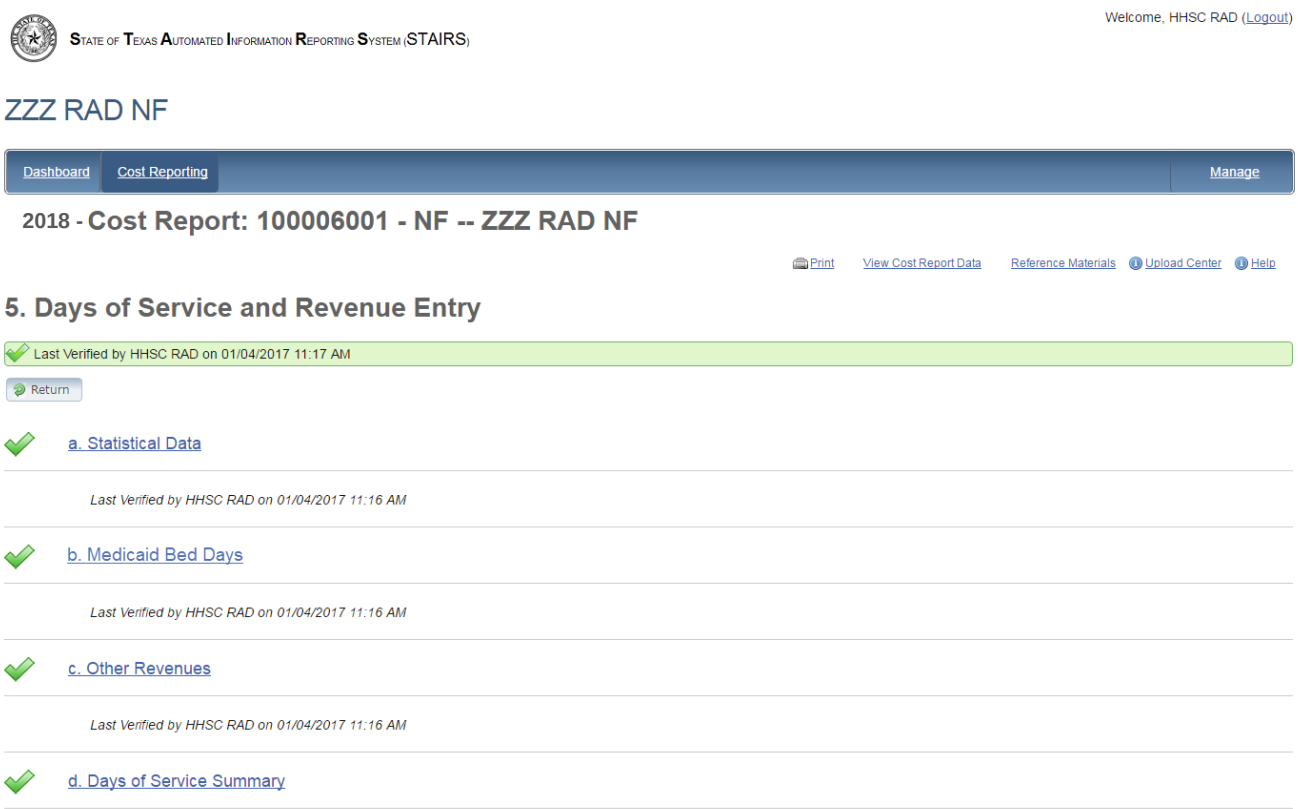
Click either "Yes" or "No". When provider clicks "Yes", then the workpapers must be uploaded to the report. There should not be situations where a provider responds to this question with "no". Each provider must maintain reconciliation work papers and any additional supporting work papers (such as invoices, canceled checks, tax reporting forms, allocation spreadsheets, financial statements, bank statements, and any other documentation to support the existence, nature, and allowability of reported information)

detailing allocation of costs to all contracts/grants/programs/business entities. In order to facilitate the audit process, it is thus required that the accountability report preparer attach a reconciliation worksheet, with its foundation being the provider's year-end trial balance. Refer to 1 TAC §355.105(b)(2)(A).
Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period?

If the response to the question above was "Yes", then ***Steps 6d and 8*** *will be grey and the preparer will not be able to make entries in those Steps.*

Recoupment of funds from facilities whose Medicaid direct care staff spending is less than their spending floor may be mitigated (i.e., reduced) if the facility has high dietary and/or fixed capital costs. This mitigation is limited to recoupment amounts based upon failure to meet direct care staff spending requirements. There is no mitigation of recoupment for failure to meet staffing requirements. Facilities claiming mitigation must complete Steps 6d and 8 of this report. Facilities waiving their right to mitigation do not have to complete Steps 6d and 8. Indicate "Yes" if you **are** waiving your right to mitigation and leave Steps 6d and 8 blank. Indicate "No" if you **are not** waiving your right to mitigation and complete Step 6d and 8.

Step 5 DAYS OF SERVICE AND REVENUE



Step 5b Bed Days:

In this screen the preparer will enter the Medicaid days of service and Resource Utilization Group (RUG) and the Non-Medicaid units of service in Medicaid contracted beds. The provider must breakdown the Medicaid units into multiple rate periods based on when the Medicaid payment rates changed during the provider's accountability report year. There will be separate entries for each rate period based on the provider's reporting period in ***Step 4***. The data should be reported based on the date of service provision and not by the date revenues were received – in other words, on the accrual basis. Bed holds or room holds are not considered units of service.

Report "pending" residents in the category believed they are most likely to be classified by DADS until they have been certified and qualified. Days for which residents were charged for "room hold" or "bed hold" are not considered as days of service and are not to be counted as resident days (see Step 5d).

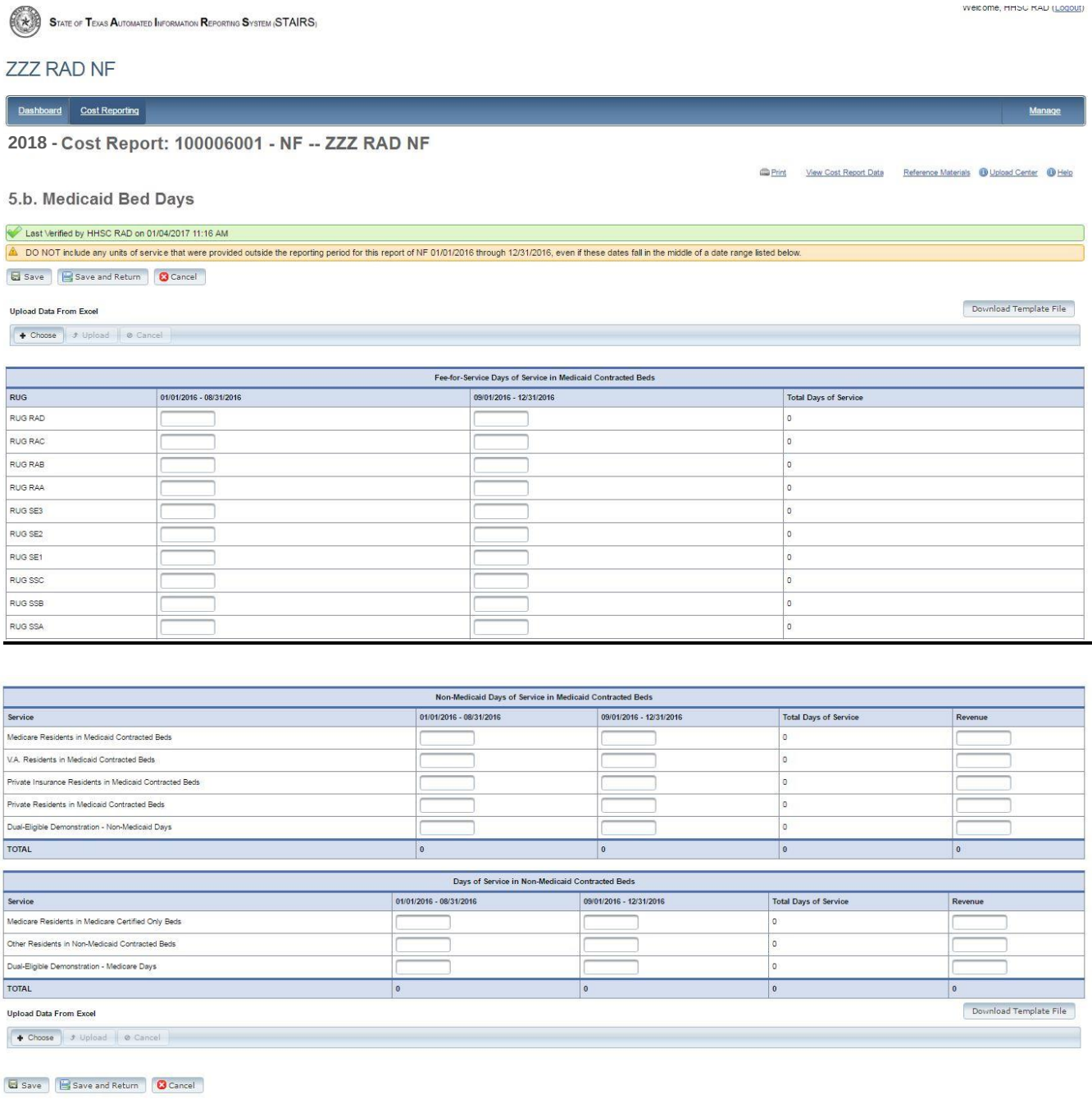
Days of service for DADS residents under the Respite program should be reported in Step 5b Private Residents in Medicaid-Contracted beds or Step 5c Other Residents in Non-Medicaid Contracted Beds, depending upon whether the bed is contracted for Medicaid or not contracted for Medicaid.

If the facility does not accept private insurance payments but a resident's family accesses private insurance for funds to pay the facility for the resident's care, the resident is considered a private resident and this resident's days of service should be reported in Step 5b Private Insurance Residents in Medicaid Contracted beds or Step 5c Other Residents in Non-Medicaid Contracted Beds, depending upon whether the bed is contracted for Medicaid or not contracted for Medicaid.

Non-Medicaid revenues include revenues received for Private residents in Medicaid-Contracted beds and revenues received for residents in Non-Medicaid-Contracted beds.

Enter the Days of Service in Non-Medicaid Contracted Beds for Medicare Residents in Medicare Certified Only Beds, Other Residents in Non-Medicaid Contracted Beds, and Dual-Eligible Demonstration - Medicare Days. These units must be broken out for each date range that falls in the reporting period

The following screenshot shows a portion of the entry screen for the units of service by RUG code; the actual step includes more RUG codes and tables for Hospice, Star+Plus, and Dual-Eligible. Following that are the screenshots for the other tables included in Step 5b.



STATE OF TEXAS AUTOMATED INFORMATION REPORTING SYSTEM (STAIRS)

Welcome, HHSC RAD (LOGOUT)

ZZZ RAD NF

Dashboard | Cost Reporting | Manage

2018 - Cost Report: 100006001 - NF -- ZZZ RAD NF

Print | View Cost Report Data | Reference Materials | Upload Center | Help

5.b. Medicaid Bed Days

Last Verified by HHSC RAD on 01/04/2017 11:16 AM

DO NOT include any units of service that were provided outside the reporting period for this report of NF 01/01/2016 through 12/31/2016, even if these dates fall in the middle of a date range listed below.

Save | Save and Return | Cancel

Upload Data From Excel

Download Template File

Choose | Upload | Cancel

Fee-for-Service Days of Service in Medicaid Contracted Beds			
RUG	01/01/2016 - 08/31/2016	09/01/2016 - 12/31/2016	Total Days of Service
RUG RAD			0
RUG RAC			0
RUG RAB			0
RUG RAA			0
RUG SE3			0
RUG SE2			0
RUG SE1			0
RUG SSC			0
RUG SSB			0
RUG SSA			0

Non-Medicaid Days of Service in Medicaid Contracted Beds				
Service	01/01/2016 - 08/31/2016	09/01/2016 - 12/31/2016	Total Days of Service	Revenue
Medicare Residents in Medicaid Contracted Beds			0	
V.A. Residents in Medicaid Contracted Beds			0	
Private Insurance Residents in Medicaid Contracted Beds			0	
Private Residents in Medicaid Contracted Beds			0	
Dual-Eligible Demonstration - Non-Medicaid Days			0	
TOTAL	0	0	0	0

Days of Service in Non-Medicaid Contracted Beds				
Service	01/01/2016 - 08/31/2016	09/01/2016 - 12/31/2016	Total Days of Service	Revenue
Medicare Residents in Medicare Certified Only Beds			0	
Other Residents in Non-Medicaid Contracted Beds			0	
Dual-Eligible Demonstration - Medicare Days			0	
TOTAL	0	0	0	0

Upload Data From Excel

Download Template File

Choose | Upload | Cancel

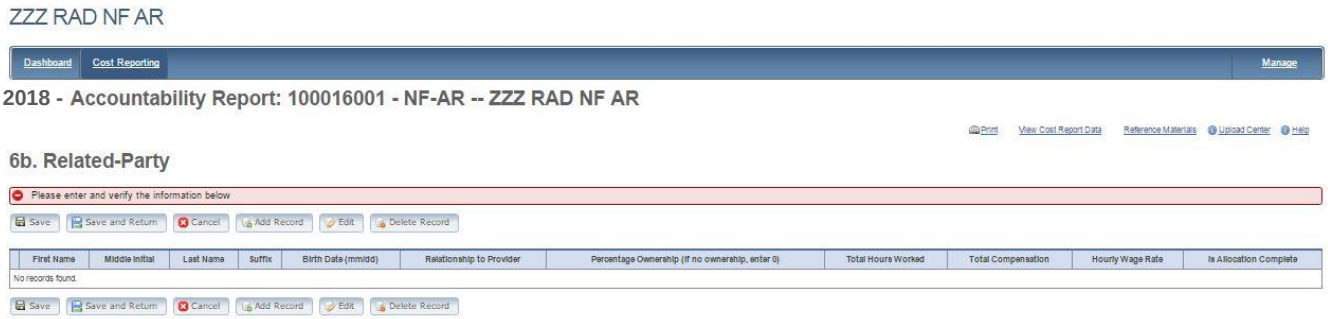
Save | Save and Return | Cancel

Step 6 WAGES AND COMPENSATION

Step 6a General Information

Do you have any Related-Party Wages and Compensation (Employee or Contractor) included in the Accountability report?
Click "Yes" or "No". See **DEFINITIONS**, *RELATED PARTY*) to determine if provider must report a related party. If the preparer clicks "Yes" then the Step on the main Wages and Compensation page called ***Step 6b*** (***Related-Party Wages and Compensation)*** will be activated for entry.

Step 6b Related-Party Wages and Compensation:

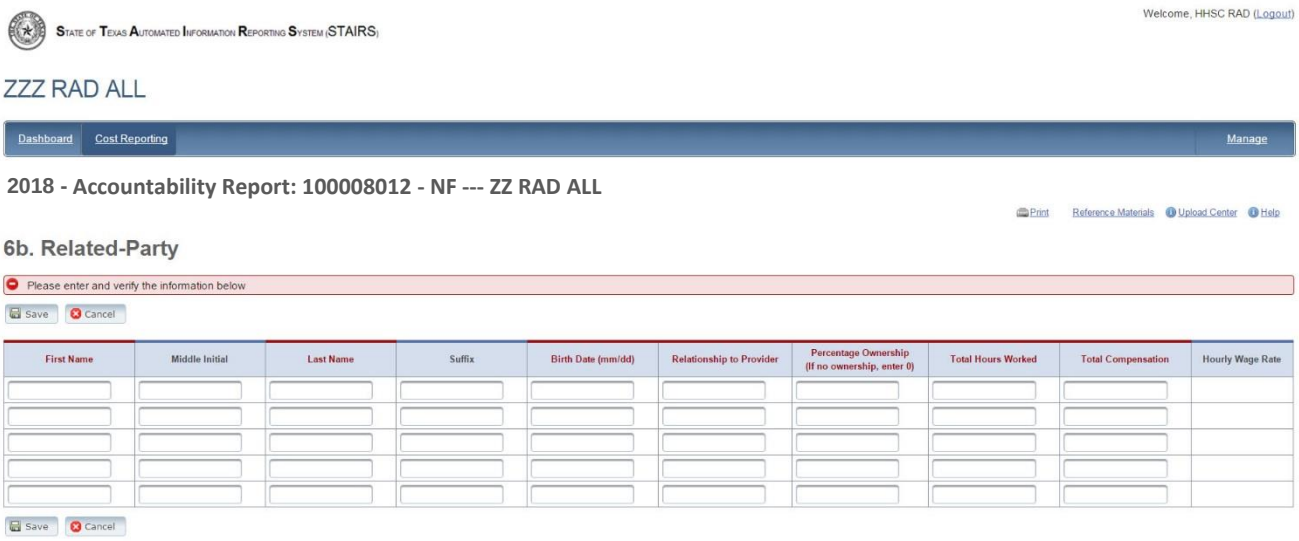


This Step will be grey and the preparer will not be able to make entries if the answer was "No" to the question regarding Related Party Wages and Compensation on ***Step 6a*** *above. If that question was erroneously answered "No", the preparer will need to return to that item and change the response to "Yes" to be able to enter data in this Step.*

Create one and only one record for each individual. If the individual worked in multiple entities or for multiple contracts, that will be designated in #2 below.

For each owner-employee, related-party employee and/or related-party contract staff:

1. *Click "Add record"*



A. First Name
B. Middle Initial
C. Last Name
D. Suffix – e.g. Jr., III, Sr.
E. Birth Date – Format as mm/dd (e.g. 10/26 for October 26). Year is not requested.
F. Relationship to Provider – This could be blood relationship (Father, Sister, Daughter, Aunt), marriage relationship (Wife, Mother-in-Law, Brother-in-Law), Ownership (in the case of a corporation or partnership), or control (membership in board of directors, membership in related board of directors, etc.)
G. Percentage Ownership (in cases of corporation or partnership)
H. Total Hours Worked – Total hours worked for all entities within the entire combined entity. If the related party was paid for a "day of service", then multiply that day by 8 to report hours.
I. Total Compensation – Total compensation (wages, salary and/or contract payments) paid to the related party by all entities within the entire combined entity. It is expected that all individuals will have received some form of compensation from within the combined entity.

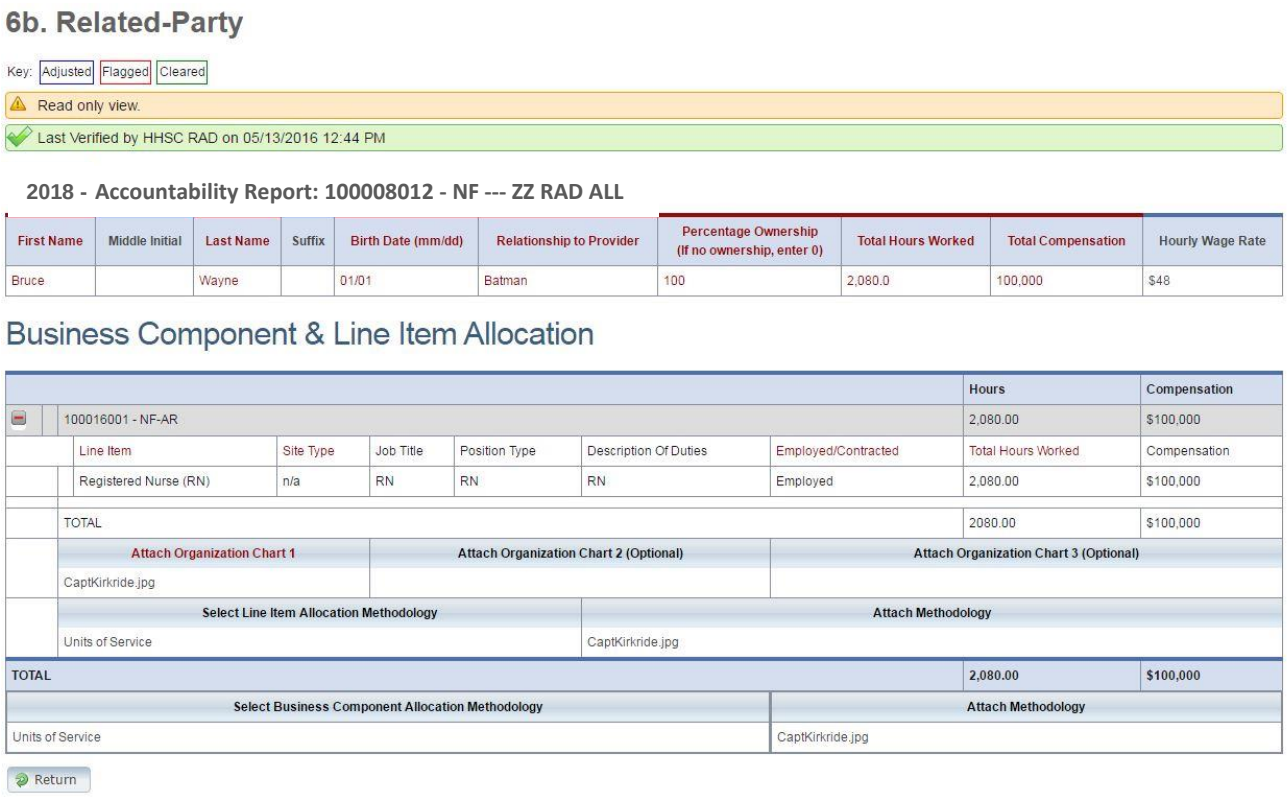
   Note: This must be actual compensation, without any adjustments based on related-party status. Any adjustments required by 1 TAC 355.105(i) will be made automatically in STAIRS during the audit process.

J. Hourly Wage Rate – Calculated figure based on Total Compensation divided by Total Hours Worked.

   Note: If the preparer needs to delete a related-party after filling out the data fields for A thru J listed above, preparer must zero out the Total Hours Worked as well as the Hours listed on the grey bar. Click on the individual to delete and on Delete Record.

2. *Click "Save" to enter Business Component and Line Item Allocation(s)*

The available business components are limited to the businesses and contracts entered in ***Step 3***. Allocate or direct cost all hours reported for the individual under Total Hours Worked and Total Compensation to a business component before proceeding. The Hourly Wage Rate will automatically be calculated. If allocated, an allocation method must be chosen and an allocation summary uploaded when prompted.



6b. Related-Party

Key: Adjusted Flagged Cleared

Read only view.

Last Verified by HHSC RAD on 05/13/2016 12:44 PM

2018 - Accountability Report: 100008012 - NF --- ZZ RAD ALL

First Name	Middle Initial	Last Name	Suffix	Birth Date (mm/dd)	Relationship to Provider	Percentage Ownership (If no ownership, enter 0)	Total Hours Worked	Total Compensation	Hourly Wage Rate
Bruce		Wayne		01/01	Batman	100	2,080.0	100,000	$48

Business Component & Line Item Allocation

							Hours	Compensation
100016001 - NF-AR							2,080.00	$100,000
Line Item	Site Type	Job Title	Position Type	Description Of Duties	Employed/Contracted		Total Hours Worked	Compensation
Registered Nurse (RN)	n/a	RN	RN	RN	Employed		2,080.00	$100,000
TOTAL							2080.00	$100,000
Attach Organization Chart 1	Attach Organization Chart 2 (Optional)				Attach Organization Chart 3 (Optional)			
CaptKirkride.jpg								
Select Line Item Allocation Methodology				Attach Methodology				
Units of Service				CaptKirkride.jpg				
TOTAL							2,080.00	$100,000
Select Business Component Allocation Methodology					Attach Methodology			
Units of Service					CaptKirkride.jpg			

Return

A. Business Component – The drop-down menu includes all business components for the provider entity. If provider entity only has one business component, the drop down menu does not appear and the single business component is automatically entered under business component.
B. Click "Add Record" **–** Generates additional lines to record Line Item information for each business component**.** Choose and Click "Add Record" until all business components to which this related party will be allocated have been added.

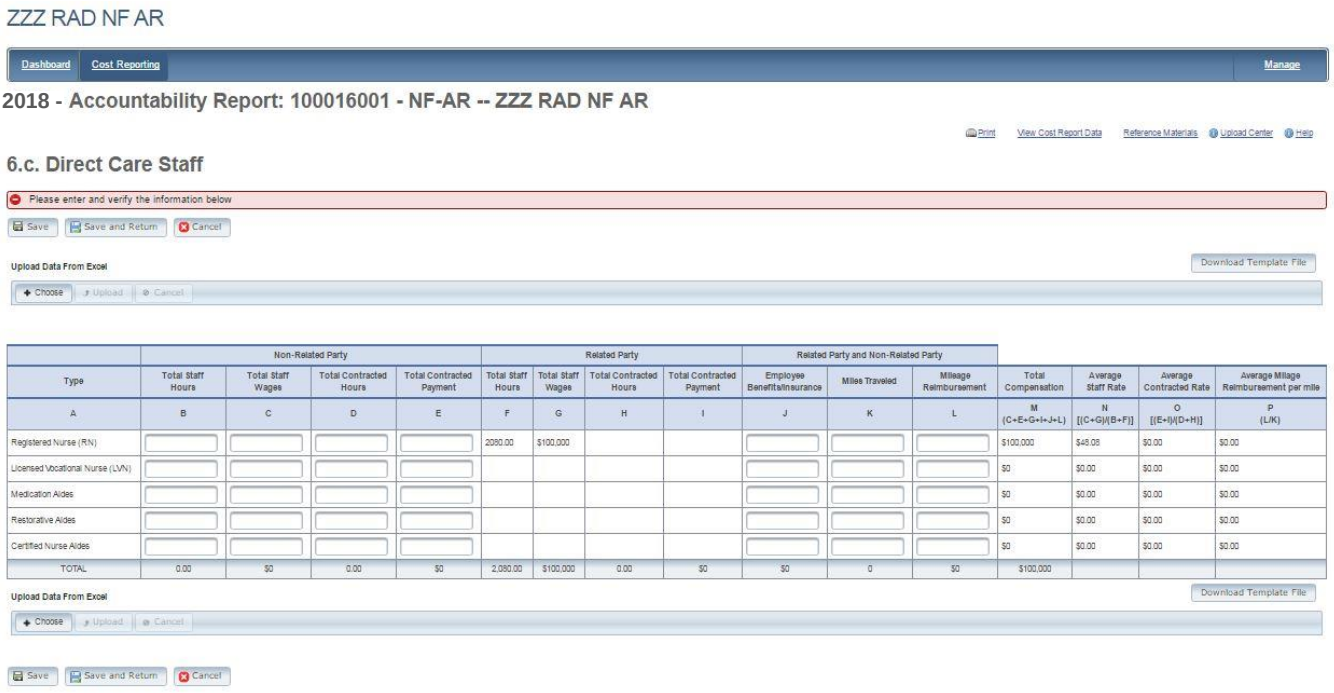
3. Enter Line Item Allocation(s)

A. Hours – On the grey bar, enter hours allocated or direct costed to each business component. Compensation amount will be automatically calculated.
B. Line Item – The drop-down menu includes all staff types reportable in this accountability report.
C. Job Title – Related Party's title within the specific business component.
D. Position Type - Identify the type of position (e.g., central office, management, administrative, direct care, nurse, or direct care supervisory) filled by the related individual.
E. Description of Duties – Provide a description of the duties performed by the related individual as they relate to the specific accountability report or upload a copy of the person's written job

description, providing a summary of how those duties relate to the specific accountability report, and reference that upload in this item.

F. Employed/Contracted – Select either Contracted or Employed. If it happens that the related party is compensated during the year both as an employee and as a contractor for the same activity, then the hours for contracted would have to be entered separately from the hours for employed.
G. Total Hours Worked – Enter hours allocated or direct costed to each area and site type. Allocate or direct cost all hours reported for the individual for the business component to an area and type before proceeding. Compensation will automatically be calculated.
H. Organizational chart – Upload an organizational chart or select from the drop down menu of documents that have already been uploaded.
I. Line Item Allocation Methodology – If allocated to multiple line items, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there were multiple line items entered.
J. Business Component Allocation Methodology – After all business component ~~line item~~ allocations have been completed, reporting a related party in multiple business components will also require that a business component allocation method be chosen and an allocation summary uploaded.

Step 6c Direct Care Staff Non-Related Party Wages and Benefits:



<u>Columns B-E: Non-Related Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment:</u> These columns are for non-related party direct care staff ONLY. All related-party direct care staff must be entered through ***Step 6b*** above. For each direct care staff type enter hours, wages and contract compensation for non-related party employees and contract staff who meet the definition of direct care staff. See **DEFINITIONS**, *<u>DIRECT CARE</u>*. Only employee and contracted staff who meet the definition of direct care staff may be reported in these cost items.

Total Staff and Contract Hours should include the total number of hours for which employees and contract labor direct care staff were compensated during the reporting period. This would include hours for both time worked and paid time off (sick leave, vacation, etc.).

Columns F-I: Related-Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment: If there are related-party employee and/or contract direct care staff reported in ***Step 6b*** above, these columns are automatically populated after all nonrelated-party costs in Columns B-E have been entered.

Column J: Employee Benefits/Insurance: This column is for BOTH related and non-related party employee direct care staff. For all direct care staff, by facility size and staff type, include the following benefits in this column. These benefits, with the exception of paid claims where the employer is self-insured, must be direct costed, not allocated.

- Accrued Vacation and Sick Leave*
- Employer-Paid Health/Medical/Dental Premiums
- Employer-Paid Disability Insurance Premiums
- Employer-Paid Life Insurance Premiums
- Employer-Paid Contributions to acceptable retirement funds/pension plans
- Employer-Paid Contributions to acceptable deferred compensation funds
- Employer-Paid Child Day Care
- Employer-Paid Claims for Health/Medical/Dental Insurance when the provider is self-insured (may be allocated)

* ACCRUED LEAVE. If the provider chooses to report accrued leave expenses not yet subject to payroll taxes, they must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages. 1 TAC §355.103(b)(1)(A)(iii)(III)(-c-).

Note: COSTS THAT ARE NOT EMPLOYEE BENEFITS Per 1 TAC §355.103(b)(1)(A)(iii)(II), the contracted provider's unrecovered cost of meals and room-and-board furnished to direct care staff, uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements and job certification renewal fees are not to be reported as benefits but are to be reported as costs applicable to specific accountability report line items in ***Step 8f***, unless they are subject to payroll taxes, in which case they are to be reported as salaries and wages. See 1 TAC §355.103(b)(1)(A)(iii)(III)(-e-) and instructions on meals for staff, supplies for staff meal preparation, staff personal vehicle mileage reimbursement and housing costs for live-in staff for further direction on the correct reporting of these costs.

Columns K and L: Miles Traveled and Mileage Reimbursement: These columns are for BOTH related and non-related party employee direct care staff. For all direct care staff, by facility size and staff type, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person's personal vehicle. Allowable travel and transportation includes mileage and reimbursements of direct care staff who transport individuals to/from services and activities of the NF in their personal vehicle, unless payroll taxes are withheld on the reimbursements, in which case they should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also

includes mileage and reimbursements of direct care staff for allowable training to which they traveled in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

- 1/1/15 – 12/31/15 57.5 cents per mile
- 1/1/16 – 12/31/16 54.0 cents per mile
- 1/1/17 – 12/31/17 53.5 cents per mile

Column M: Total Compensation: This column is the sum of Columns C, E, G, I, J and L and represents Total Direct Care Compensation for that facility type and staff type.

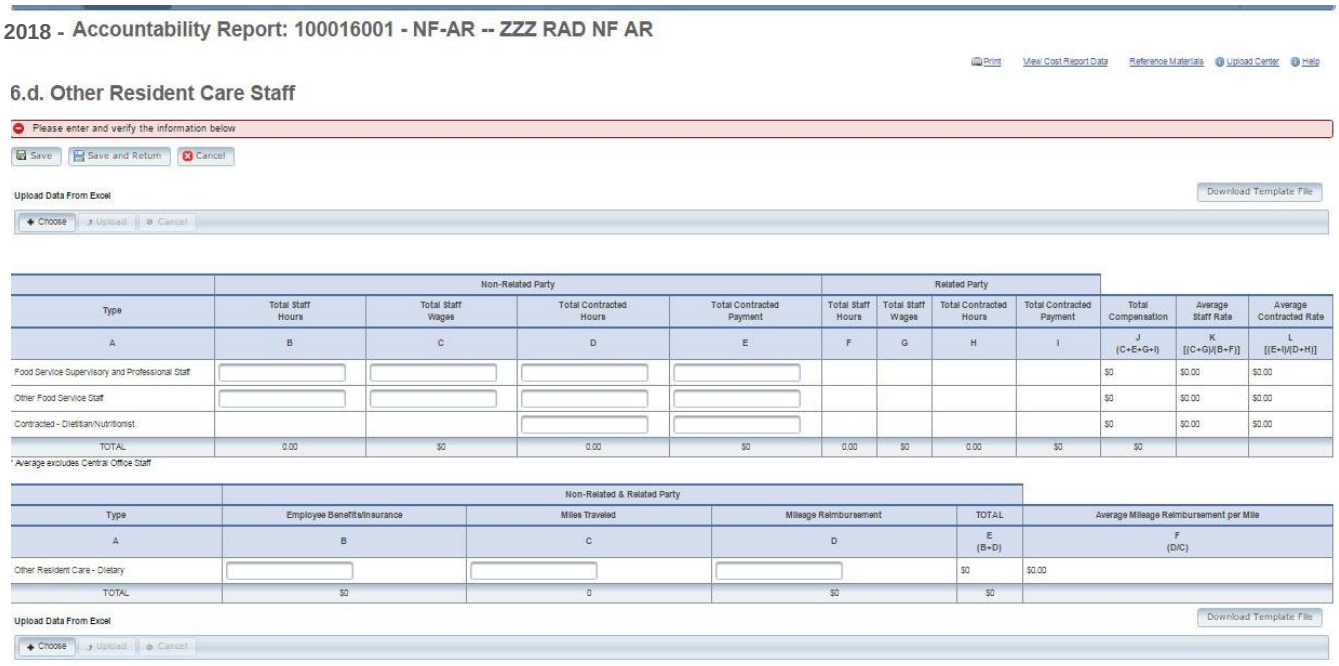
Column N: Average Staff Rate: This column is the result of Columns C + G divided by Columns B + F and represents the average hourly wage rate of all employee staff, both related party and non-related party.

Column O: Average Contract Rate: This column is the result of Columns E + I divided by Columns D + H and represents the average hourly contract rate of all contract staff, both related party and non-related party.

Column P: Average Mileage Reimbursement per Mile: This column is the result of Column L divided by Column K. This amount should never be greater than the highest allowable mileage rate for the provider's fiscal year.

Step 6d Other Resident Care Staff Non-Related Party Wages and Benefits:

*If the response to the question "Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period" in **Step 4** was "Yes", then **Step 6d** will be grey and the preparer will not be able to make entries.*



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6.d. Other Resident Care Staff

Please enter and verify the information below

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	Non-Related Party				Related Party						
Type	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H	I	J (C+E+G+I)	K [(C+G)/(B+F)]	L [(E+I)/(D+H)]
Food Service Supervisory and Professional Staff									$0	$0.00	$0.00
Other Food Service Staff									$0	$0.00	$0.00
Contracted - Dietitian/Nutritionist									$0	$0.00	$0.00
TOTAL	0.00	$0	0.00	$0	0.00	$0	0.00	$0	$0		

* Average excludes Central Office Staff

	Non-Related & Related Party				
Type	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement	TOTAL	Average Mileage Reimbursement per Mile
A	B	C	D	E (B+D)	F (D/C)
Other Resident Care - Dietary				$0	$0.00
TOTAL	$0	0	$0	$0	

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For the upper sections (by facility type – only facility types contracted by the provider will be visible):
Columns B-E: Non-Related Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment: These columns are for non-related party staff of the listed staff types only. Compensation for administrative staff types will be collected in a separate Step of the accountability report. All related-party staff must be entered through ***Step 6b*** above. For each facility and for each staff type enter hours, wages and contract compensation for non-related party employees and contract staff. See staff type descriptions below. All staff reported here perform either non-direct care or indirect care functions.

Total Staff and Contract Hours should include the total number of hours for which employees and contract staff were compensated during the reporting period. This would include hours for both time worked and paid time off (sick leave, vacation, etc.).

Pay for being "on-call" is reported as salaries by staff type but only on-call hours actually worked performing a specific function can be reported as time. For example, if a RN was on call for an entire weekend and received $200 as on-call compensation, the total $200 would be reported as wages or compensation. If the RN was required for three hours to provide assistance to staff while on-call during the weekend, only three hours would be reported as paid hours and not the full 48 hours of the weekend.

Allocation of Shared Dietary/Central Kitchen Expenses

A central kitchen is defined as a kitchen that provides meals and/or snacks to more than one contract, component code program, or business entity. If the provider had a central kitchen that prepared meals for more than one business entity or NF contract, the accountability report preparer CANNOT report the expense of the meals provided for this NF contract as a single line item entry on the accountability report. Shared dietary/central kitchen expenses must be reported on the accountability report in the various line items that reflect the types of expense (i.e. Dietary Staff wages and compensation in this cost item and facility, equipment, food and dietary supplies expenses in ***Step 8.***

If dietary care services are shared by more than one business component (e.g., with an adult day care, residential care, independent living and/or child day care) or multiple NFs, the shared dietary costs must be properly allocated. If the services are provided by a central kitchen, see ***APPENDIX C - Allocation of Shared Dietary/Central Kitchen*** for details as to proper allocation of these expenses.

Columns F-I: Related-Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment: If there are related-party employee and/or contract staff as described above reported in *Step 6b*, these columns are automatically populated after all nonrelated-party costs in Columns B-E have been entered.

Column J: Total Compensation: This column is the sum of Columns C, E, G, and I, and represents Total Direct Care Compensation for that facility type and staff type.

Column K: Average Staff Rate: This column is the result of Columns C + G divided by Columns B + F and represents the average hourly wage rate of all employee staff, both related party and non-related party.

Column L: Average Contract Rate: This column is the result of Columns E + I divided by Columns D + H and represents the average hourly contract rate of all contract staff, both related party and non-related party.

Other Resident Care - Dietary:

Column A: Employee Benefits/Insurance: This column is for BOTH related and non-related party employee direct care staff. For all direct care staff, by facility size and staff type, include the following benefits in this column. These benefits, with the exception of paid claims where the employer is self-insured, must be direct costed, not allocated.

- Accrued Vacation and Sick Leave*
- Employer-Paid Health/Medical/Dental Premiums
- Employer-Paid Disability Insurance Premiums
- Employer-Paid Life Insurance Premiums
- Employer-Paid Contributions to acceptable retirement funds/pension plans
- Employer-Paid Contributions to acceptable deferred compensation funds
- Employer-Paid Child Day Care
- Employer-Paid Claims for Health/Medical/Dental Insurance when the provider is self-insured (may be allocated)

* ACCRUED LEAVE. If the provider chooses to report accrued leave expenses not yet subject to payroll taxes, they must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages. 1 TAC §355.103(b)(1)(A)(iii)(III)(-c-).

Note: COSTS THAT ARE NOT EMPLOYEE BENEFITS Per 1 TAC §355.103(b)(1)(A)(iii)(II), the contracted provider's unrecovered cost of meals and room-and-board furnished to direct care staff, uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements and job certification renewal fees are not to be reported as benefits but are to be reported as costs applicable to specific accountability report line items in ***Step 8f***, unless they are subject to payroll taxes, in which case they are to be reported as salaries and wages. See 1 TAC §355.103(b)(1)(A)(iii)(III)(-e-) and instructions on meals for staff, supplies for staff meal preparation, staff personal vehicle mileage reimbursement and housing costs for live-in staff for further direction on the correct reporting of these costs.

Columns B and C: Miles Traveled and Mileage Reimbursement: These columns are for BOTH related and non-related party employee direct care staff. For all direct care staff, by facility size and staff type, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person's personal vehicle. Allowable travel and transportation includes mileage and reimbursements of direct care staff who transport individuals to/from services and activities of the NF in their personal vehicle, unless payroll taxes are withheld on the reimbursements, in which case they should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also includes mileage and reimbursements of direct care staff for allowable training to which they traveled in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

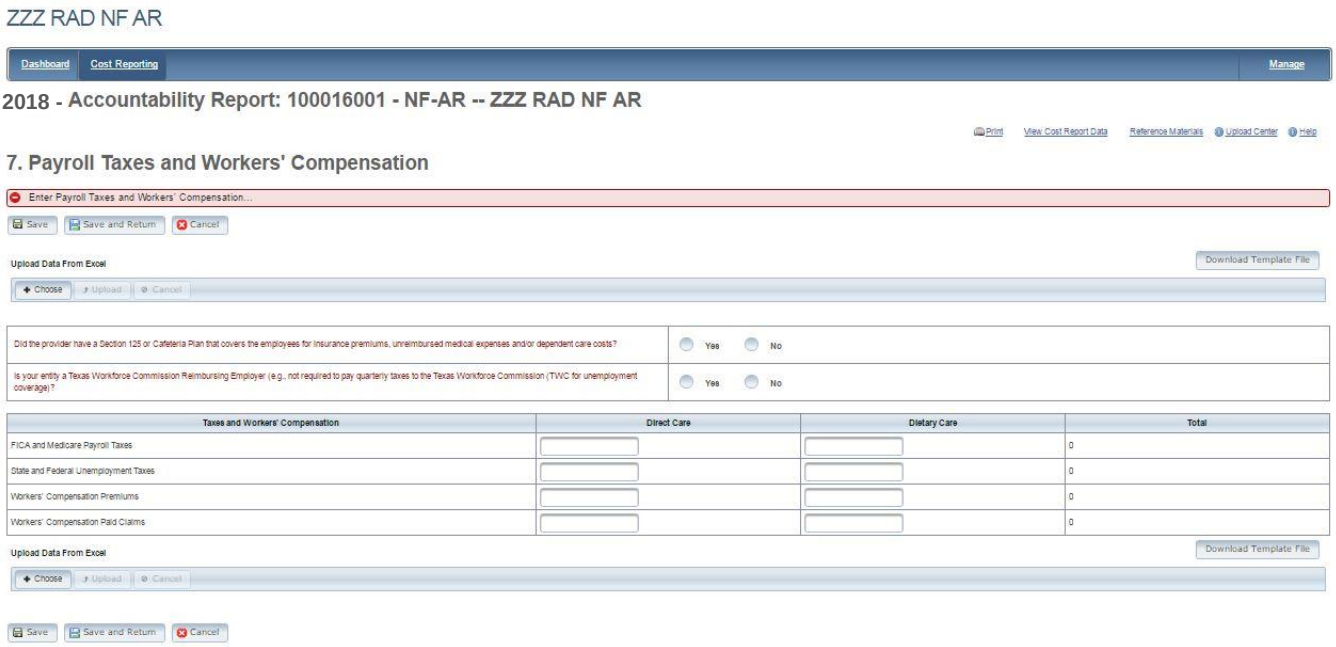
- 1/1/15 – 12/31/15 57.5 cents per mile
- 1/1/16 – 12/31/16 54.0 cents per mile
- 1/1/17 – 12/31/17 53.5 cents per mile

Column F: Average Mileage Reimbursement per Mile: This column is the result of Column D divided by Column C. This amount should never be greater than the highest allowable mileage rate for the provider's fiscal year.

Step 7 PAYROLL TAXES AND WORKERS' COMPENSATION

Report costs for all staff in this Step. Report costs for direct care staff, non-direct care staff/ program administration (non-central office) employees and central office employees separately

If payroll taxes (i.e. FICA, Medicare, and state/federal unemployment) are allocated based upon percentage of salaries, the provider must disclose this functional allocation method. The use of percentage of salaries is not the salaries allocation method, since the salaries allocation method includes both salaries and contract labor.



Did the facility have a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs?
Click either "Yes" or "No". If "Yes" is clicked, provider must upload supporting documentation or select a file from the drop down menu of documents that have already been uploaded.

Is your entity a Texas Workforce Commission Reimbursing Employer?
Click either "Yes" or "No". If "Yes" is clicked, provider must upload supporting documentation or select a file from the drop down menu of documents that have already been uploaded.

For the following taxes, list separately, those for Non-Central Office and for Central Office staff:

FICA & Medicare Payroll Taxes:
Report the cost of the employer's portion of these taxes. Do not include the employee's share of the taxes. Unless the provider has indicated that they participate in a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs or the provider has reported staff who are paid in excess of the FICA Wage Limit, ($127,200 for 2017, $128,400 for 2018), this amount must equal 7.65% of reported wages.

State and Federal Unemployment Taxes:
Report both federal (FUTA) and Texas state (SUTA) unemployment expenses.

Workers' Compensation Premiums:
If the facility is a subscriber to the Workers' Compensation Act, report here the Worker's Compensation insurance premiums paid to the provider's commercial insurance carrier. If the effective period of the provider's Workers' Compensation insurance policy does not correspond to the provider's fiscal year, it will be necessary to prorate the premium costs from the two policy periods falling within the provider's reporting period to accurately reflect the costs associated with the cost-reporting period. Premium costs include the base rate, any discounts for lack of injuries, any refunds for prior period overpayments, any additional modifiers and surcharges for experiencing high numbers of injuries (such as being placed in a risk pool), and any audit adjustments made during the cost-reporting period. The Texas Workers' Compensation Commission audits traditional Workers' Compensation insurance policies yearly and annual adjustments must be properly applied to the cost-reporting period on a cash basis.

If the facility is not a subscriber to the Workers' Compensation Act, there are alternate insurance premium costs that can be reported in this item. Acceptable alternate insurance policies include industrial accident policies and other similar types of coverage for employee on-the-job injuries. Disability insurance and health premiums are ***not*** considered alternate workers' compensation policies and those costs must be reported as employee benefits (if subject to payroll taxes, they must be reported as salaries). A general liability insurance policy, according to the Texas Department of Insurance, specifically excludes payment for employee on-the-job injuries; therefore, general liability premium costs must not be reported on this item.

If the provider's commercially purchased insurance policy does not provide total coverage and has a deductible and/or coinsurance clause, any deductibles and/or coinsurance payments made by the employer on behalf of the employee would be considered claims paid (i.e., self-insurance) and must be reported in the ***Workers' Compensation Paid Claims*** item below.

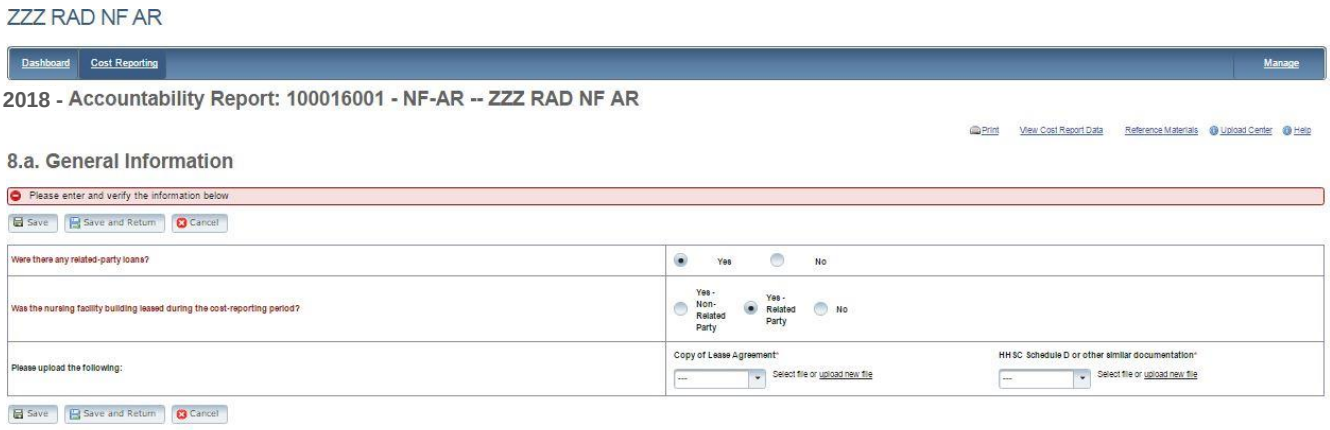
Workers' Compensation Paid Claims:
If the provider was not a subscriber to the Workers' Compensation Act (i.e., traditional workers' compensation insurance policy), and paid workers' compensation claims for employee on-the-job injuries, report the amount of claims paid. Also report the part of any workers' compensation litigation award or settlement that reimburses the injured employee for lost wages and medical bills here unless the provider is ordered to pay the award or settlement as back wages subject to payroll taxes and reporting on a W-2, in which case the cost should be reported in **Step 6**. Note that only the part of the litigation award or settlement that reimburses the injured employee for lost wages and medical bills is allowable on this accountability report. If the provider maintained a separate bank account for the sole purpose of paying

workers' compensation claims for employee on-the-job injuries (i.e., a nonsubscriber risk reserve account), the contributions made to this account are not allowable on the accountability report. This type of arrangement requires that the contracted provider be responsible for payment of all its workers' compensation claims and is not an insurance-type account or arrangement. A nonsubscriber risk reserve account is not required to be managed by an independent agency or third party. It can be a separate checking account set aside by the contracted provider for payment of its workers' compensation claims. However, only the amount for any claims paid should be reported on the accountability report, not the amount contributed to any (reserve) account. There is a cost ceiling to be applied to allowable self-insurance workers' compensation costs or costs where the provider does not provide total coverage and that ceiling may limit the costs, which may be reported. See 1 TAC §355.103(b)(13)(B) and 1 TAC §355.105(b)(2)(B)(ix) and ***APPENDIX.E: - Self-Insurance.***

Step 8 FACILITY AND OPERATIONS COSTS

If the response to the question "Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period" in ***Step 4*** *was "Yes", then* ***Step 8*** *will be grey and the preparer will not be able to make entries.*

Step 8a General Information:



Were there any related-party loans?
Click either "Yes" or "No". If "Yes", ***Step 8c (Related-Party Loans)*** will become available for entry of related-party loan transactions. Refer to **DEFINITIONS**, *RELATED PARTY* and *RELATED-PARTY TRANSACTIONS*.

Was the nursing facility building leased during the accountability reporting period?
Indicate whether or not the nursing facility building was leased during all or part of the accountability report period, and if so, indicate whether it was leased from a Non-Related Party or a Related Party. If the facility was leased during any part of the accountability report period, you will need to upload a Copy of the Lease Agreement, and HHSC Schedule D1 or other similar documentation. Submission of the lease agreement with a prior year's accountability report does not exempt a facility from the requirement to submit another copy with the current Schedules and attachments to the accountability report.

Steps 8b-8d Related-Party Transactions
Note: Steps 8b and 8d are not required data for the Accountability Report.

See 1 TAC §355.102(i) for specific details and requirements on related-party transactions. *If the response to the question "Were there any related-party loans"* ***Step 8a*** *above was "No", then* ***Steps 8c*** *will be grey and the preparer will not be able to make entries. If that question was erroneously answered "No", the preparer will need to return to that item and change the response to "Yes" to be able to enter data in these three Steps.*

The lease or purchase of services (including lending/loan services), facilities, equipment and supplies from related organizations or related individuals by the provider or the provider's central office must be reported as a related-party transaction. Note that for depreciation expenses, related-party status is disclosed separately for each depreciable item when depreciation, amortization and other expenses for related-party and non-related-party assets are entered. In addition, purchases made from a related party by the central office for services, facilities, and supplies must also be reported as related party transactions. An exception is central office costs allocated to the provider that contain no markup (i.e., the cost allocated to the provider is the cost incurred by the central office); these do not have to be reported as related party transactions. This exception does not apply to related-party management costs; these costs must always be reported as central office costs.

Expenses in related-party transactions are allowable at the cost to the related organization; however, the cost must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased or leased elsewhere in an arm's-length transaction. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, leases, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if the contracted provider itself incurred them. Therefore, if a cost would be unallowable if incurred by the contracted provider, it would be similarly unallowable to the related organization.

See **DEFINITIONS**, *RELATED PARTY* and *RELATED-PARTY TRANSACTIONS*.

EXCEPTIONS TO THE RELATED-PARTY RULE

An exception (1 TAC §355.102(i)(5)) is provided to the general rule applicable to related organizations if the contracted provider demonstrates for each accountability report that certain criteria have been met. If all of the conditions of this exception are met, the charges by the related-party supplier to the contracted provider for services, equipment, facilities, leases, or supplies are allowable costs and do not have to be reported as related-party transactions. Written requests for an exception to the general rule applicable to related organizations must be submitted for approval to HHSC's Rate Analysis Department no later than 45 days prior to the due date of the accountability report in order to be considered for that year's accountability report. The provider's request for an exception must demonstrate that all of the following criteria have been met:

1. The supplying organization is a bona fide separate organization. See 1 TAC §355.102(i)(5)(A).

2. A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control. See 1 TAC §355.102(i)(5)(B).

3. There is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the related organization. See 1 TAC §355.102(i)(5)(B).

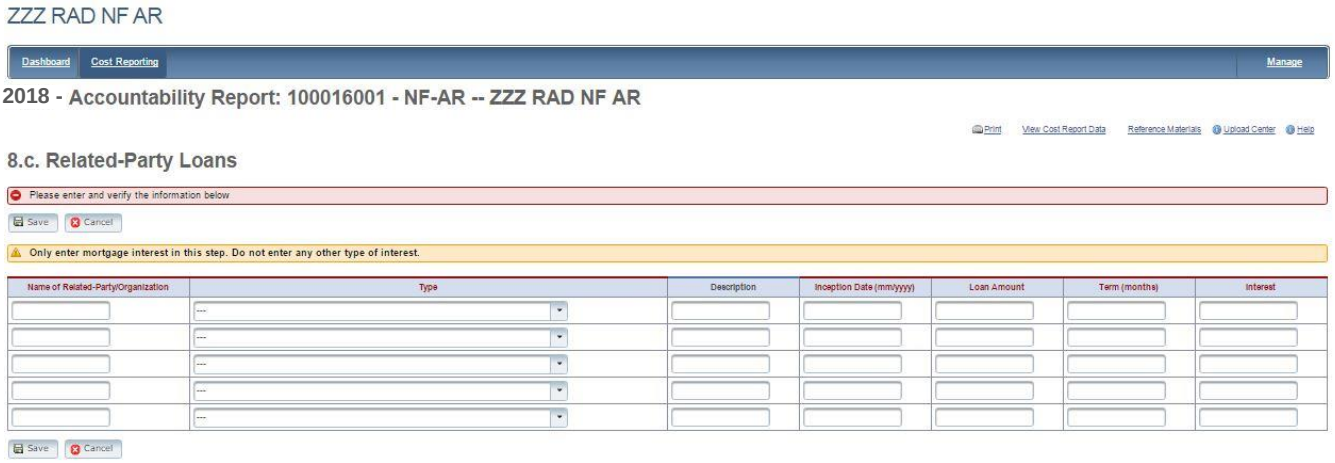
4. The services, equipment, facilities, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted care ordinarily furnished directly to individuals by such entities. See 1 TAC §355.102(i)(5)(C).

5. The charge to the contracted provider is comparable to open market prices and does not exceed the charge made to others by the organization for such services, equipment, facilities, leases or supplies. See 1 TAC §355.102(i)(5)(D).

If Medicare has made a determination that a related-party situation does not exist or has granted an exception to the related-party definition, and the provider desires that HHSC accept that determination, the accountability report preparer must submit a copy of the applicable Medicare determination, along with evidence supporting the Medicare determination for the current cost-reporting period with each affected accountability report. If the exception granted by Medicare is no longer applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, HHSC can choose not to accept the Medicare determination. *See 1 TAC §355.102(i)(5).* If the request for a related-party exception is not received at least 45 days prior to the due date of the accountability report, HHSC Rate Analysis is not required to process the request for that cost-reporting year.

Step 8c Related-Party Loans

Report in this Step any related-party loans from individuals or organizations. Actual interest properly accrued and paid on related-party loans is an allowable cost, but is limited to the interest that would have been charged during the reporting period had the interest rate on the loan been set at the prevailing national average prime interest rate in effect at the time at which the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis, in the Survey of Current Business. For those with Internet access, the quickest source of prime interest rate information is the Federal Reserve Bank of St. Louis Web Site (http://www.stlouisfed.org/) under Research and Data, FRED® (Federal Reserve Economic Data) Economic Data, Categories, Interest Rates, and Prime Bank Loan Rate. This data series extends back to 1949 and is updated monthly.

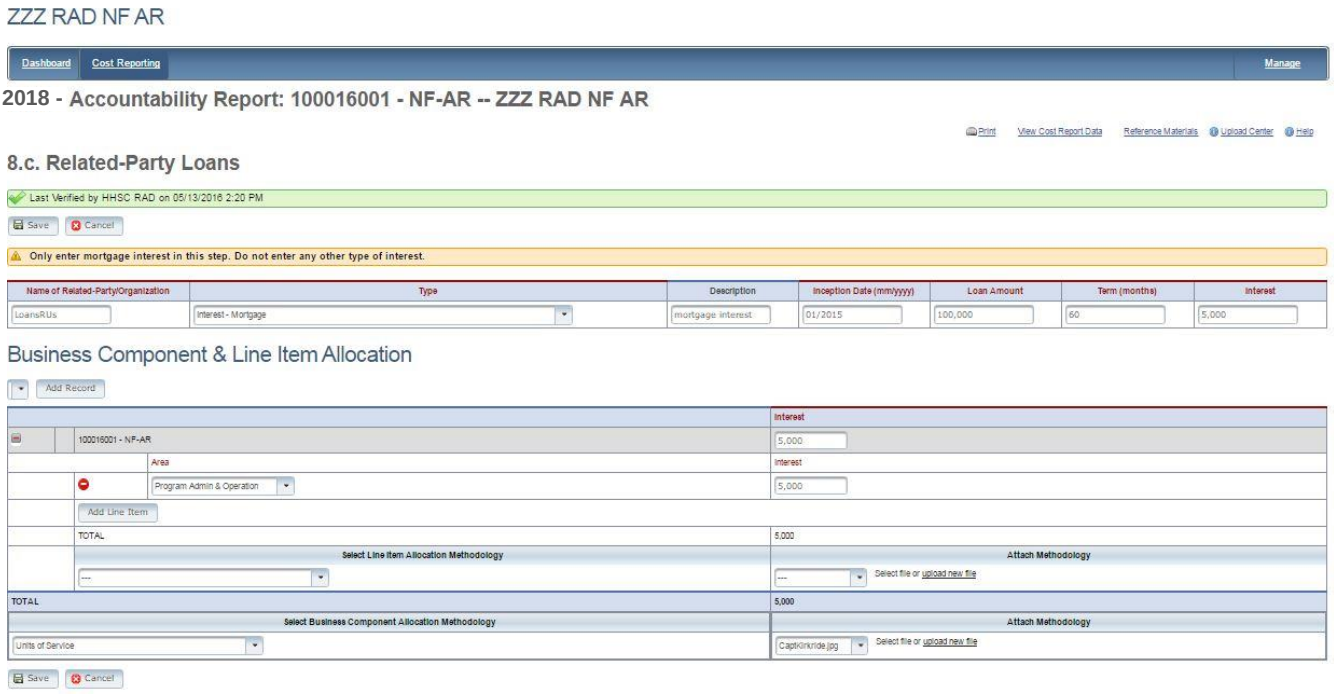


All columns must be completed for each related individual or organization.

A. Name of Related Party/Organization – Enter the name of the related party or organization from whom the contracted NF purchased or leased equipment and/or supplies. If the contracted provider is a proprietorship, the related organization could be the individual owner rather than a separate corporation. If the contracted provider is a partnership, the related organization could be one of the partners.
B. Description – Must be chosen from the drop-down menu – either Mortgage Interest or Other. This is the line item on which the allowable cost will appear in the accountability report.
C. Please describe – If Other was chosen for B above, describe the type of loan.
D. Inception Date – Month and year the loan was effective.
E. Loan Amount – This should be the total amount of the loan.
F. Term – Duration of the loan in months.
G. Interest – Allowable interest paid during the reporting period.

1. *Click "Save" to enter Contract Number and Cost Area Allocation(s)*

The available business components are limited to the businesses and contracts entered in the ***Step 3***. If a business component that should receive a portion of the allocated cost of the item(s) is not in the drop down menu, then the preparer should return to ***Step 3b*** and enter the missing business component data. Allocate or direct cost all interest reported for the Related Party/Organization to a business component before proceeding. If allocated, an allocation method must be chosen and an allocation summary uploaded.



A. Business Component – The drop-down menu includes all business components for the provider entity. If provider entity only has one business component, the drop-down menu does not appear and the single business component is automatically entered under business component.
B. Click "Add Record" – Generates additional lines to record Cost Area information for each business component. Choose and Click "Add Record" until all business components to which this interest expense will be allocated have been added.

2. *Enter all Cost Area Information*

A. Interest – On the grey bar, enter the allowable interest expense allocated or direct costed to each business component.

B. Area – The dropdown menu for "Area" includes all cost areas reportable in this accountability report. See ***Step 8f*** for a detailed discussion of Cost Areas. Central Office may only be used for expenses of a central office that are allocated between multiple business components. Costs of a central office which can be directly charged to the contracted provider should be reported as Program Administration. See **DEFINITIONS**, *CENTRAL OFFICE*.

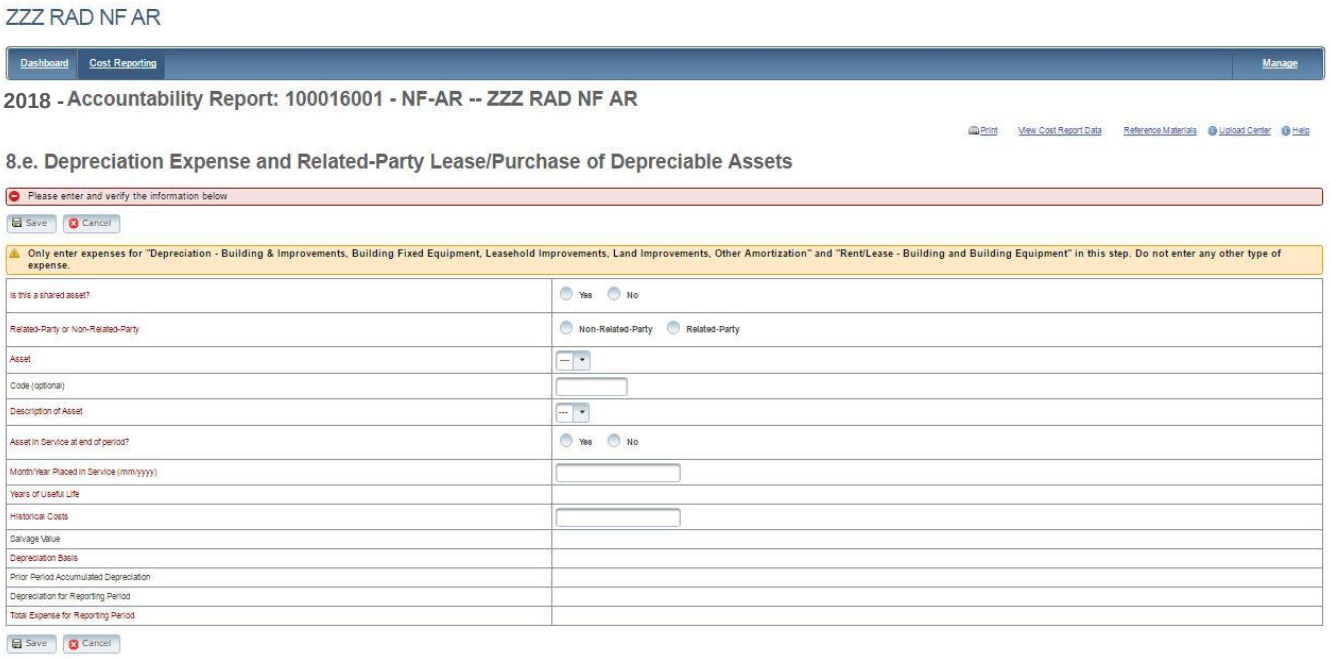
C. Interest – Enter the allowable interest expense direct costed or allocated to this cost area within the business component.

D. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there were multiple cost areas selected.

E. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense that is allocated to multiple business components will also require that a business component allocation method be chosen and an allocation summary uploaded.

Step 8e Depreciation Expense (Depreciation and Amortization) and Related-Party Purchase or Lease of Depreciable Assets

Providers have an option of reporting each single capital asset in Step 8e and allowing the system to depreciation expense per category at the summary level in Step 8e.



Depreciable asset information automatically populates from year to year after the initial entry. After the first year, providers will only need to adjust allocations of shared assets to correctly report current year

allocation percentages and add new assets. A provider with numerous assets may want to import their basic asset information. This information may be imported into STAIRS. See ***APPENDIX F – Importing Data Into STAIRS.***

NOTE: If a provider, in a subsequent year's accountability report, chooses to enter their depreciation at the summary level any previously entered depreciable asset data will be deleted upon submission of the accountability report.

For cost-reporting purposes, property and assets owned by the contracted provider and improvements to the provider's owned, leased, or rented property that are valued at $5,000 or more with an estimated useful life of more than one year at the time of purchase must be depreciated. Any single item costing less than $5,000 should be expensed and reported as supplies in the applicable cost area. For example, a non-depreciable mixer/blender would be reported as Food and Dietary Supplies; a non-depreciable calculator and a non-depreciable resident nightstand would be reported as Resident Care and Operations Supplies.

Depreciation for depreciable items must be calculated using the appropriate Steps of the accountability report.

For depreciable assets leased from a related party, all costs to be entered are the cost to the related party, not payments by the contracted provider to the related party. For depreciable assets purchased from a related party, the cost entered must be the cost to the related party and not the amount actually paid by the contracted provider for the asset purchased.

NOTES

Allowable depreciation expense includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable.

Include only assets of the contracted provider or its central office that are used directly or indirectly in the provision of resident care during the cost-reporting period. For shared central office depreciation, show the percentage allocated to the contracted provider for which the accountability report is being prepared and cross-reference to the applicable allocation summary. For shared facility-level depreciation (e.g., depreciation of assets whose usage is shared between the contracted provider and another entity), show the amount allocated to the contracted provider by cost area and cross-reference the applicable allocation summary.

Required detail must be provided for each depreciable asset and each depreciable asset will be assigned a correct estimated useful life as required by 1 TAC §355.103(b)(10)(A-C).

1. *Click "Add Record"*

A. Is this a shared asset? – Click "Yes" or "No". If "Yes", the preparer will be asked to allocate the asset between business components and cost areas after saving. If "No", the system will automatically assign the asset to the current accountability report.

B. Related-Party or Non-Related Party – Click "Related Party" if the asset was purchased or leased from a related party or "Non-Related Party" if the asset was purchased from a nonrelated party.

NOTE - Only Related-Party leases are reported through the Depreciation screens. Nonrelated-party leases are reported in ***Step 8f***.

C. Asset – This is the line item on which the allowable cost will appear in the accountability report. If it is a related-party lease, then a drop-down menu with additional expense types will be available for entry of related-party cost. The various types of assets include:

a) Depreciation: Buildings and Building Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization

i. ***Buildings and Building Improvements:*** structures (and depreciable improvements to those structures) consisting of building shell or frame, building components, exterior walls, interior framing, walls, floors, and ceilings. The building cost can also include a proportionate share of architectural, consulting, and interest expense (incurred during the construction of the building, not mortgage interest) associated with a newly constructed or renovated building (including major additions). Buildings do not include central air conditioning systems and trade fixtures, unless they were part of the building when purchased/renovated. Building improvements that are structural in nature (renovations) should be depreciated as if they were a building. Such improvements should be assigned a life of at least 30 years and a salvage value of at least 10%. When a portion of a building is renovated and all parts of the renovation are placed in service at or about the same time, the renovation should be depreciated as a single depreciable asset over 30 years and not over the estimated life of each of its components. Building improvements that are not structural in nature and do not extend the depreciable life of the building, but whose estimated useful lives are longer than the remaining depreciable life of the building, must be depreciated over the normal useful life of the building improvements. Providers who rent or lease their building must report any building improvement depreciation as leasehold improvement depreciation.

ii. ***Building Fixed Equipment:*** any equipment which is attached to the building and is intended to be permanent, such as central air conditioning systems and trade fixtures. Providers who rent or lease the facility must report any building fixed equipment depreciation as leasehold improvements depreciation.

iii. ***Leasehold Improvements:*** improvements a lessee makes to a leased building. These improvements are attached to the building or land in a permanent way. They become the property of the lessor when the lease is terminated. Examples of leasehold improvements are permanent trade fixtures, additions, and betterments. All building equipment and land improvements purchased by a lessee, that are valued at $5,000 or more at the time of purchase with an estimated useful life of more than one year must be classified as a leasehold improvement and amortized. Leasehold improvements whose estimated lives are longer than the lease term must be amortized over the life of the leasehold improvement.

iv. ***Land Improvements:*** assets found on the land area contiguous to, and designed for serving, the contracted provider such as fences, sidewalks, driveways, parking lots, etc. The asset can include a proportionate share of the architectural, consulting, and interest

expense associated with newly constructed or renovated buildings. Providers who rent or lease the facility must report land improvement depreciation as leasehold improvement depreciation.

v. ***Research and Development (R&D), Organizational and Start-up:*** must be amortized over a period of at least sixty months. R&D costs include those costs related to determining the business feasibility of obtaining a contract and can include costs such as demographic research and consulting fees. Organizational costs may include costs such as legal fees, state incorporation fees, stock certificate costs, underwriting costs, and office expenses incident to organizing the company. Start-up costs include those costs related to employee training, licensing, utilities, facility cleaning, and other preparations that are incurred before the first individual (whether Medicaid or non-Medicaid) is admitted to the program. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation as described in the Cost Determination Process Rules. Any costs that are properly identifiable as capitalizable construction costs must be appropriately classified as such and excluded from startup costs. *Costs related to care for individuals that are incurred after the first individual is admitted, but before the provider is Medicaid-certified, are unallowable costs.*

b) Depreciation: Departmental Equipment: any equipment capable of being moved from one site to another, such as all types of furniture, appliances, office machines, and any other items of equipment which are necessary operating assets.

c) Depreciation: Transportation Equipment: equipment used for the transport of individuals in care, staff or materials and supplies utilized by the provider in the provision of contracted care. Depreciation expenses for transportation equipment not generally suited or not commonly used to transport individuals in care, staff, or provider supplies are unallowable costs. This includes motor homes and recreational vehicles, sports automobiles, motorcycles, heavy trucks, tractors and equipment used in farming, ranching and construction. Lawn tractors are to be reported as departmental equipment.

d) (for related party only) Rent/Lease - Building and Building Equipment: includes the assets in a) i. through iv. above that are rented or leased from a related party. Additional expense types for possible building-related costs to the related-party are optional entries.

i. Mortgage Interest – Mortgage interest for the property leased to the contracted provider that was properly accrued and paid by the related party.

ii. Interest-Other – Other interest expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

iii. Property Tax – Property tax payments for the property leased to the contracted provider that were properly accrued and paid by the related party.

iv. Insurance Expense – Insurance expenses for the property leased to the contracted provider that were properly accrued and paid by the related party.

v. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

e) (for related party only) Rent/Lease – Departmental Equipment: includes the assets in b) above. Additional expense types for possible departmental equipment-related costs to the related-party are optional entries.

i. Interest-Other – Other interest expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

ii. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

f) ***(for related party only) Rent/Lease – Transportation Equipment:*** includes the assets in c) above. Additional expense types for possible departmental equipment-related costs to the related-party are optional entries.

i. Transportation-Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other – Enter here only the Interest, Insurance and/or Repair and Maintenance expenses directly related to the transportation equipment leased to the contracted provider that were properly accrued and paid by the related party.

ii. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

D. Code (optional) – For internal provider use.

E. Month/Year Placed in Service (mm/yyy) - Enter the month and year that the asset to be depreciated was placed in service.

F. Description of Asset – This will be chosen from a drop-down menu populated from the AHA Guide discussed in Years of Useful Life below. If the preparer does not find the type of asset and cannot determine a close match, contact the Rate Analyst to determine if a new asset type should be added.

NOTE: If Building is selected, a drop-down menu will request an address. If the building is being leased (related parties only), a lease agreement must be uploaded.

G. Asset in Service at end of Period? – Click "Yes" or "No" to note whether this item was in service at the end of the accountability reporting period. If "Yes", enter the Month / Year placed in service. If "No", enter the Month / Year placed in service and the Month / Year removed from service.

H. Years of Useful Life – The time period over which the asset must be depreciated. STAIRS populates this based on the Description entered in E. above for all assets except Used Vehicles. Also see ***APPENDIX D - A List of Some Useful Lives for Depreciation***

Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (2008 Version Item Number - Item No. 061179 ISBN: 978-1-55648-358-5).

Copies of this publication may be obtained by contacting:

Mail: AHA Services, Inc.; P.O. Box 933283; Atlanta, GA 31193-3283
Toll Free: 800-242-2626 Fax: 866-516-5817
Website: www.healthforumonlinestore.com

For Used Vehicles, determine the required useful life and enter that. Per 1 TAC 355.103(b)(10)(C)(ii), "The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years. For example, if a 2014 van were purchased in 2015, it would have four years remaining in its five-year depreciable life and that would become the depreciable life for the used vehicle. If a 2014 minivan were purchased in 2015, it would have two years remaining in its three-year depreciable life and the depreciable life for the used vehicle would then be three years."

I. Historical Cost – The cost of acquiring the asset and preparing it for use. Does not include goodwill or, for buildings, the cost of the land (land is not a depreciable item).

J. Salvage Value – This amount will be calculated automatically. Salvage value is the estimated residual value of the asset for scrap or salvage after its useful life has ended. All buildings must

have a minimum salvage value of at least 10% of historical cost for Medicaid cost-reporting purposes. No other salvage values are required.

K. Depreciation Basis – Calculated figure equal to H minus I.

L. Prior Period Accumulated Depreciation – Calculated figure. Based on date placed in service and calculation of depreciation on the Depreciation Basis from that date to the beginning date of the accountability reporting period.

M. Depreciation for Reporting Period – Calculated figure. Based on the date placed in service, the beginning date of the accountability reporting period, any date entered as Month/Year removed from service) and the remaining useful life.

N. Total Expense for Reporting Period – Calculated figure. For Related-party leases, this will include costs from C. ***d) – f)*** above, as well as the depreciation on the asset.

2. Click "Save" to enter Business Component and Cost Area Allocation(s)

Business Component – The available business components are limited to the businesses and contracts entered in ***Step 3***. If a business component that should receive a percentage of the asset or related-party leased items is not on the list, then the preparer should return to ***Step 3b*** and enter the missing business component data. Allocate or direct cost 100% of the asset costs a business component before proceeding. If allocated, an allocation method must be chosen and an allocation summary uploaded.

A. Business Component – The drop-down menu includes all business components for the provider entity. If provider entity only has one business component, the drop-down menu does not appear and the single business component is automatically entered under business component.

B. Click "Add Record" – Generates additional lines to record Cost Area information for each business component. Choose and Click "Add Record" until all business components to which this expense will be allocated have been added.

C. Information in the Business Component Grey Bar –

a) Asset in Service at End of Period? – The response for the business component will default to "Yes" if the Asset information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single business component, but not for all. The allocation of an asset may also change

throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

b) Month/Year Placed in Service – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific business component.

c) Month/Year Removed from Service – If the asset was removed from service for this business component during the current year, then enter the month and year that the asset was removed from service.

d) Allocation % – The percentage of the costs to be allocated to this specific business component.

e) Expense for Reporting Period – Calculated figure based on the percentage(s) entered.

3. Enter all Cost Area Information

A. Area – The dropdown menu for "Area" includes all cost areas reportable in this accountability report. See ***Step 8f*** for a detailed discussion of Cost Areas. Central Office may only be used for expenses of a central office that are allocated between multiple business components. Costs of a central office which can be directly charged to the contracted provider should be reported as Program Administration. See **DEFINITIONS**, *CENTRAL OFFICE*.

B. Asset in Service at End of Period? – The response for the cost area will default to "Yes" if the business component information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single cost area, but not for all. The allocation of an asset may also change throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

C. Month/Year Placed in Service – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific cost area.

D. Month/Year Removed from Service – If the asset was removed from service for this cost area during the current year, then enter the month and year that the asset was removed from service.

- The two lines above (c and D) also allow for changes in allocation percentages throughout the year. By entering an end date at the point where the allocation changes and adding an additional record with a new 'placed in service date' for the new allocation period, the usage changes will be taken into account in the calculation of the depreciation below.

E. Allocation % – The percentage of the costs to be allocated to this specific cost area.

F. Expense for Reporting Period – Calculated figure based on the percentage(s) entered.

G. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there were multiple cost areas selected.

H. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense that is allocated to multiple business components will also require that a business component allocation method be chosen and an allocation summary uploaded.

Step 8f Non-Related Party Facility, Operations, Administrative and Other Direct Care Costs

This screen consists of a column for the Line Item Names and three columns for Nonrelated-Party Cost Areas and three columns for Related-Party Cost Areas, a column to Total all expenses in each line item and a column for notes. The three columns each Non-Related Party and Related Party correlate to the Program Admin & Operations and Central Office Cost Areas, plus a Total. Facility and Operations costs should be reported if the Provider owns/operates its own Residential facility and/or Day Habilitation facility or has a Program Administration office (even if that office shares space with the Residential or Day Habilitation building). Even if building/facility costs are paid by/through a central office, the portion of the building/facility and operations costs directly related to the NF contract should be reported in the specific cost area as appropriate. These cost areas are intended for the reporting of facility and operations costs that directly support the NF contract for which the accountability report is being prepared. It is important to report all costs in the correct cost area.

The first column of this screen comprises all the Facility, Operations and Administration non-staff line items. Each of these line items will be discussed in detail below. Some of the items may be reportable only in certain cost areas. Where this is the case, the accountability report will not allow entry in the cost area(s) where that type of expense may not be reported.

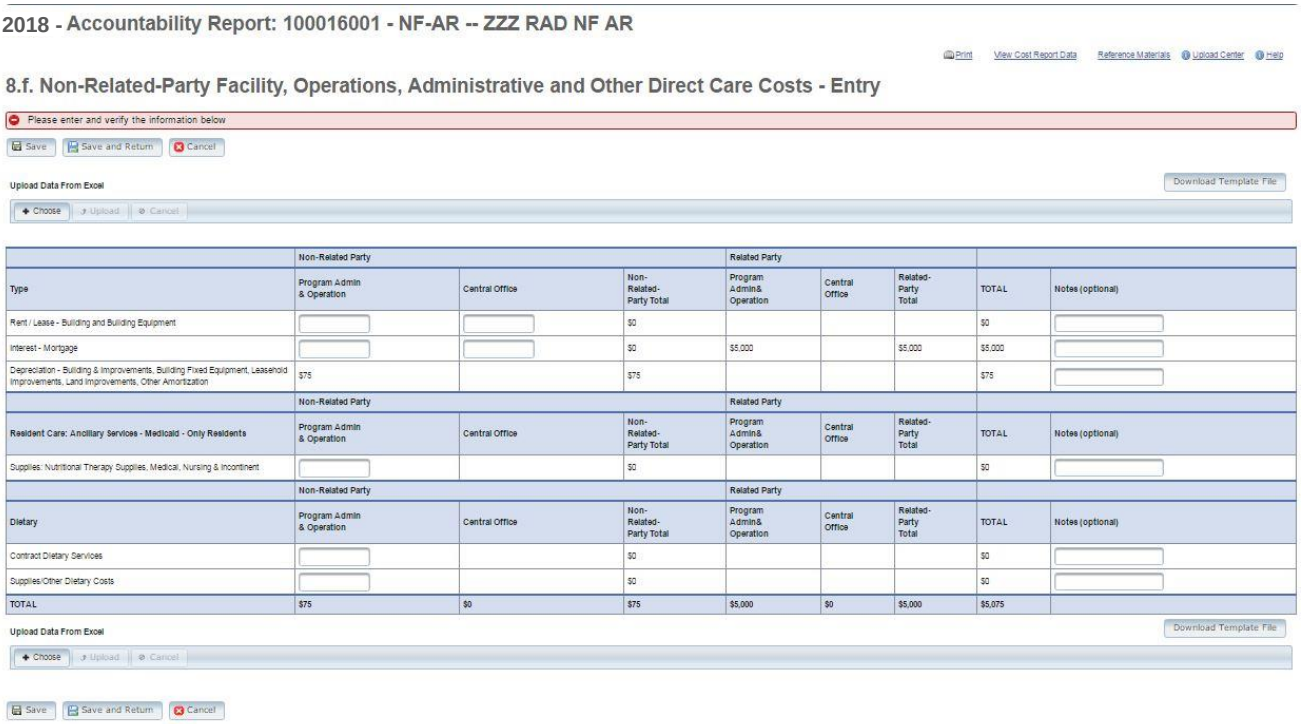
Cost Areas

Program Administration & Operations

- The Program Administration & Operations cost area is intended to capture administrative expenses associated with direct program management of the facility itself. These are considered program administrative expenses and should be directly chargeable to the facility. There should be no allocated costs reported in the program administration cost area, with the exception of an administrator allocated from the central office.

Central Office

- The Central Office cost area is intended to capture the allocated portion of shared (i.e., central office) administrative costs. For example, if documentation supports allowable legal fees directly related to the management of this facility, those legal fees should be reported in the Program Administration & Operations cost area. However, if the allowable legal fees were related to the corporation or related organization as a whole (e.g., general employee policies and procedures), the allocated portion would be reported in the Central Office cost area. If an outside accountant prepared the accountability report for the facility, the cost should be directly charged to the Program Administration & Operations cost area. If an outside accountant prepares financial statements for the parent company or sole member, the allocated portion of those costs applicable to the NF facility(s) must be reported in the Central Office cost area.
- Allowable central office costs include those costs necessary for the provision of resident care for contracted services in Texas and an appropriate share of allowable indirect costs. Costs that are unallowable to the contracted provider are also unallowable as central office costs. Central office costs must be reported at the actual cost to the central office with no markup.
- The Central Office cost area of the accountability report is self-contained; meaning that all allocated costs associated with the central office are reported in that cost area and should not be reported anywhere else on the accountability report. For detailed information on allocation methods for shared costs, see ***APPENDIX B – Allocation Methodologies***.



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8.f. Non-Related-Party Facility, Operations, Administrative and Other Direct Care Costs - Entry

Please enter and verify the information below

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	Non-Related Party			Related Party				
Type	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Rent / Lease - Building and Building Equipment			$0				$0	
Interest - Mortgage			$0	$5,000		$5,000	$5,000	
Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization	$75		$75				$75	
	Non-Related Party			Related Party				
Resident Care: Ancillary Services - Medicaid - Only Residents	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent			$0				$0	
	Non-Related Party			Related Party				
Dietary	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Contract Dietary Services			$0				$0	
Supplies/Other Dietary Costs			$0				$0	
TOTAL	$75	$0	$75	$5,000	$0	$5,000	$5,075	

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Line items will accept entry into various nonrelated-party cost areas depending on the line item type. Depreciation expense does not accept direct entry because all depreciation is entered in ***Step 8e***. Certain line items are considered indirect costs only and can only be entered in the Program Administration or Central Office cost areas. All related-party facility and operations expense transactions must be entered in the appropriate Step of STAIRS and will be transferred onto this screen.

1. <u>Rent/Lease – Building and Building Equipment</u>

A. Report NF building and building equipment lease/rental costs in this item.

B. If the rental/lease of a building is from a related party, do not enter directly here. The lease and related costs must be entered in ***Step 8e***. The calculated cost to the related party will be transferred here.

C. If the rental/lease of building equipment is from a related party, do not enter directly here. The lease must be entered in ***Step 8b*** if the building equipment is non-depreciable (items costing less than $5,000 or with a useful life of less than one year) or ***Step 8e*** if the building equipment is depreciable (items with a cost of $5,000 or more and a useful life of more than one year).

D. Lease deposit payments are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the specified time noted in the lease, the amount of deposit not refunded and used for allowable costs is allowable for cost-reporting purposes at that time. Lease deposits made for remodeling and purchase of replacement items/fixtures are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the specified time noted in the lease, the amount of deposit not refunded and used for allowable remodeling and purchase of replacement items/fixtures is allowable for reporting as repairs/maintenance or depreciation, whichever appropriate.

E. Lease deposit payments made for goodwill (see **DEFINITIONS**, <u>*GOODWILL*</u>) are not allowable costs.

2. Interest – Mortgage – See 1 TAC §355.103(b)(11). Reasonable and necessary interest on current and capital indebtedness is an allowable cost.
   A. Report the interest expense accrued from the purchase of a facility (i.e., mortgage interest) in this item. If the provider is a nonprofit entity and issued bonds for the purchase of the facility, report the bond issuance costs in this item.
   B. If a related party funded the loans, do not enter directly here. Enter through ***Step 8c.***
   C. Late payment fees and penalties are unallowable costs.
   D. Interest on vehicle loans should be reported in Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other below.
   E. Interest on working capital loans, departmental equipment loans, loans for the purchase of building improvements, building renovations, and building equipment and other operational notes should be reported in Interest – Other below.
3. Depreciation – Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization – Enter all buildings, building improvements, building fixed equipment, leasehold improvements, land improvements and amortizable items with a cost of $5,000 or more and a useful life of more than one year in ***Step 8e***. The calculated depreciation will be transferred here.
4. Medical, Nursing & Incontinent –Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent - Nutritional Therapy Food Supplies includes the costs of parenteral and enteral nutritional products. Do not include the costs of supplies and specialized staff related to the delivery of these products to the resident; those costs should be reported in Item #43 below. "Ensure" and similar products are not considered ancillary products and the costs of "Ensure," etc., should be reported as food costs in item 233.
5. Contract Dietary Services - See 1 TAC §355.102(b)(2)(C). Report on this item the cost incurred for contract dietary services (other than those for contracted/consultant dietitians/nutritionists reported in Step 6d). Do not include the rental/lease of dietary/kitchen departmental equipment (e.g., dishwasher, freezer, ice machine, or range); those costs should be reported in item #2 above.
6. Supplies / Other Dietary Costs - Report expenses for fresh, frozen, canned or dried meats, vegetables, fruits, and beverages. Report special dietary supplements such as crackers, cookies, and other snacks. Report expenses for oral nutritional therapy food supplies such as "Ensure" or "Jevity", (these are not considered ancillary services for Medicaid accountability reporting purposes). Report any associated charges made to non-Medicaid residents for oral nutritional therapy food supplies as part of the routine daily revenues for the appropriate resident category. Report costs net of any purchase discounts, rebates, returns or allowances. Food costs related to meals served to nursing facility guests and nursing facility employees must be removed through Schedule F. See instructions for Schedule F for additional information. If costs are not reported for food supplies in this item, please enter an explanation in the Notes box. Report in this item the nutritional supplements delivered by the total parental nutrition (TPN) systems and enteral nutrition (EN) systems were reported in item #36 above. See instructions for Schedule G. Report expenses for dishes, flatware, utensils, paper products, detergents, reference books and other resource materials used to plan meals and provide necessary nutritional services. Report costs net of any purchase discounts, rebates, returns or allowances. Nondepreciable equipment should be reported as supplies in this item. Effective for purchases made on or after the beginning date of the provider's 2004 fiscal year, nondepreciable equipment is equipment that cost less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that cost $5,000 or more and has a

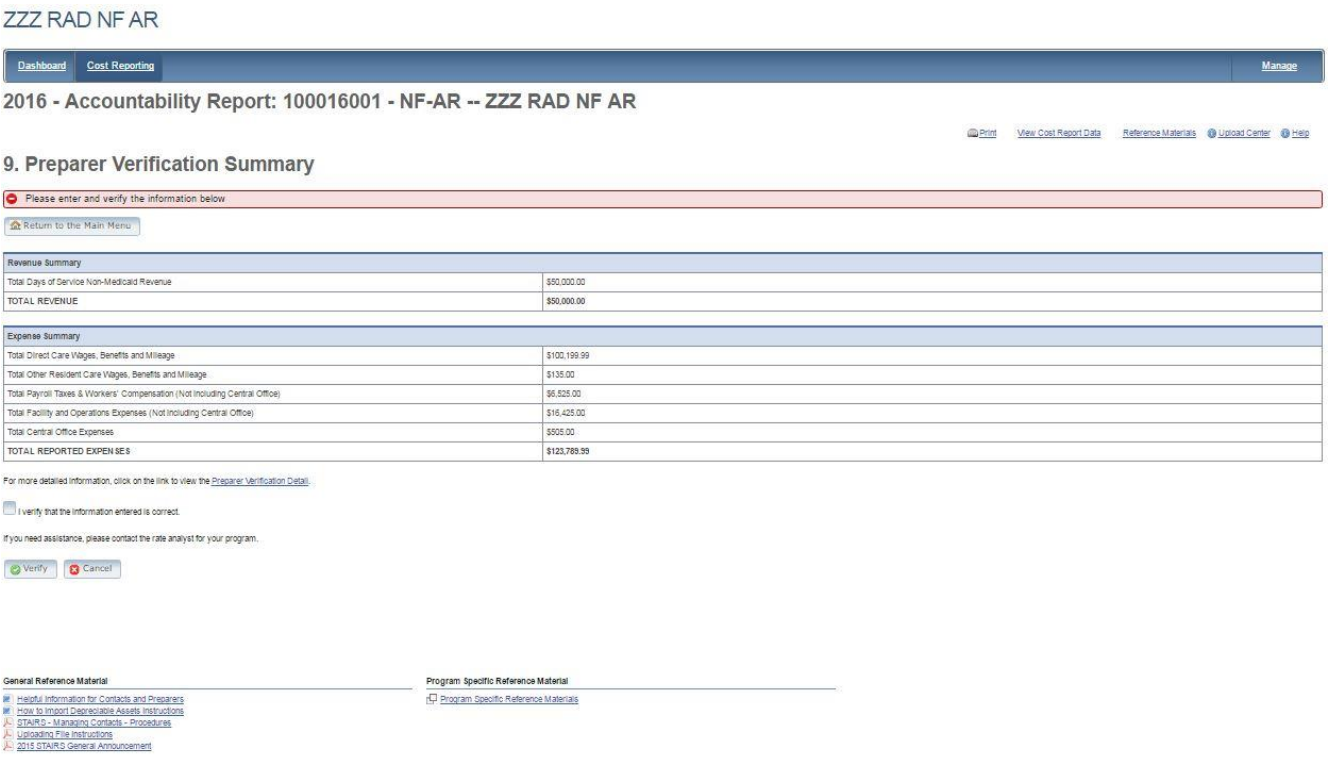
useful life of more than one year. As well, purchases made before the provider's 2004 fiscal year that cost more than $1,000 and have a useful life of more than one year must be depreciated using the straight line method. For all contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 2015, an asset valued at $5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than the capitalization level for that fiscal period as described above or having a useful life of one year or less. All depreciable equipment, whether purchased or leased from a related party or not, is to be reported in Step 8.e. Repairs and maintenance costs for dietary equipment are reported in item #7 above, regardless of the cost of the equipment. Examples of costs to be reported in this item would include costs related to the drug testing of dietary employees, physicals for dietary employees, Hepatitis B vaccinations for dietary employees, TB testing/x-rays for dietary employees, mileage reimbursement for dietary employees, and seminar costs for dietary employees. Rental of dietary equipment should be reported in item #2 above. Nondepreciable repairs and maintenance costs for dietary departmental equipment should be reported in item #10 above; depreciable repairs and maintenance costs for dietary departmental equipment should be reported in item #7 above.

Step 8g Facility and Operations Costs Summary

This Step provides a summary of the Related and Non-Related-Party Costs entered through ***Steps 8b-8f***. This view is more compact than the data entry for ***Step 8f***. The preparer may review these totals against the accountability report preparation workpapers to assure that all costs are correctly captured.

ONLINE VERIFICATION AND SUBMISSION

Step 9 PREPARER VERIFICATION SUMMARY



After all items for the accountability report have been completed, the report is ready for verification. The summary verification screen shows the Total Reported Revenues and Total Reported Expenses entered into STAIRS. These figures should be checked against the preparer's work papers to assure that all intended non-Medicaid revenues and expenses have been entered.

A link to the Preparer Verification Detail Report is included at the bottom of the page. This provides the detail of all units of service and expenses entered.

Once the preparer has determined that everything is entered correctly, the report can be verified. The preparer will check the box beside the phrase "I verify that the information entered is correct." Then click the Verify box at the bottom.

Steps 10 and 11 PREPARER CERTIFICATION AND ENTITY CONTACT CERTIFICATION

Certification pages cannot be printed for signing and notarizing until the report has been verified. If the report is reopened for any reason, any previously uploaded certifications will be invalidated and must be completed again.

A preparer may print out both the Preparer and Entity Contact Certification pages at the same time. Once one of the Certification pages is printed, the accountability report is completed and locked. If it is discovered that additional changes need to be made, the preparer must contact the Rate Analyst for assistance in getting the report(s) reopened.

Certification pages must contain original signatures and original notary stamps/seals when uploaded to STAIRS. These pages must be maintained in original form by the provider. If these pages are not properly completed, the accountability report will not be processed until the provider uploads completed pages; if completed pages are not uploaded in a timely manner, the accountability report will not be counted as received timely and may be returned. If a report is returned, it is unverified and new certifications, dated after the report has been re-verified will have to be uploaded.

- *METHODOLOGY CERTIFICATION* - This page must be signed by the person identified in ***Step 1*** of this accountability report as *PREPARER.* This person must be the individual who actually prepared the accountability report or who has primary responsibility for the preparation of the accountability report for the provider. Signing as *PREPARER* carries the responsibility for an accurate and complete accountability report prepared in accordance with applicable methodology rules and instructions. Signing as *PREPARER* signifies that the preparer is knowledgeable of the applicable methodology rules and instructions and that the preparer has either completed the accountability report himself/herself in accordance with those rules and instructions or has adequately supervised and thoroughly instructed his/her employees in the proper completion of the accountability report. Ultimate responsibility for the accountability report lies with the person signing as *PREPARER.* If more than one person prepared the accountability report, an executed Methodology Certification page (with original signature and original notary stamp/seal) may be submitted by each preparer. All persons signing the methodology certification must have attended the required accountability report training.

- *ACCOUNTABILITY REPORT CERTIFICATION* This page must be completed and signed by an individual legally responsible for the conduct of the provider such as an owner, partner, Corporate Officer, Association Officer, Government official, or L.L.C. member. The HCS/TxHmL administrator may not sign this certification page unless he/she also holds one of those positions. The responsible party's signature must be notarized. The signature date must be the same or after the date the preparer signed the Methodology Certification page, since the accountability report certification indicates that the accountability report has been reviewed after preparation.

10. Preparer Certification

Please read, sign, print and notarize the following certification statement. You must upload the signed method certification before uploa

By printing this certification form you will no longer be able to make changes to this cost report or any component codes associated w

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ZZZ RAD NF AR **Component Code: 100016001 - NF-AR**

AS PREPARER OF THIS COST REPORT, I HEREBY CERTIFY THAT:

- I have completed the state-sponsored cost report training for this cost report.
- I have read the note below, the cover letter and all the instructions applicable to this cost report.
- I have read the Cost Determination Process Rules (excluding 24-RCC), program rules, and reimbursement methodology applicable to this cost report, which define allowable and unallowable costs and provide guidance in proper cost reporting.
- I have reviewed the prior year's cost report audit adjustments, if any, and have made the necessary revisions to this period's cost report.
- To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with the Cost Determination Process Rules (excluding 24 RCC), program rules, reimbursement methodology and all the instructions applicable to this cost report.
- This cost report was prepared from the books and records of the contracted provider and/or its controlling entity.

Note: This PREPARER CERTIFICATION must be signed by the individual who prepared the cost report or who has the primary responsibility for the preparation of the cost report. If more than one person prepared the cost report, an executed PREPARER CERTIFICATION may be submitted by each preparer. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment.

PREPARER IDENTIFICATION

Name of Contracted Provider:

Printed/Typed Name of Signer: | Title of Signer:

SIGNATURE OF PREPARER

DATE

Subscribed and sworn before me, a Notary public on the _____ of _____, _____.
Day Month Year

Notary Signature

Notary Public, State of

Commission Expires

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2018 - Accountability Report: 100016001 - NF-AR -- ZZZ RAD NF AR

11. Entity Contact Certification

Read only view.

By printing this certification form you will no longer be able to make changes to this cost report or any component codes associated with this

Return

ZZZ RAD NF AR

Component Code: 100016001 - NF-AR

AS SIGNER OF THIS COST REPORT, I HEREBY CERTIFY THAT:

- I have read the note below, the cover letter and all the instructions applicable to this cost report.
- I have read the Cost Determination Process Rules (excluding 24-NCC), program rules, and reimbursement methodology applicable to this cost report, which define allowable and unallowable costs and provide guidance in proper cost reporting.
- I have reviewed this cost report after its preparation.
- To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with the Cost Determination Process Rules (excluding 24 NCC), program rules, reimbursement methodology and all the instructions applicable to this cost report.
- This cost report was prepared from the books and records of the contracted provider and/or its controlling entity.

Note: The COST REPORT CERTIFICATION must be signed by the individual legally responsible for the conduct of the contracted provider, such as the Sole Proprietor, a Partner, a Corporate Officer, an Association Officer, or a Governmental Official. The administrator/director is authorized to sign only if he/she holds one of these positions. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment.

SIGNER INDENTIFICATION

Name of Contracted Provider:

Printed/Typed Name of Signer:

Title of Signer:

Name of Business Entity:

Address of Signer (street or P.O. Box, city, state, 9-digit zip):

Phone Number (including area code):

FAX Number (including area code):

Email:

SIGNATURE OF SIGNER

DATE

Subscribed and sworn before me, a Notary public on the ____ of ____ , ____

Day Month Year

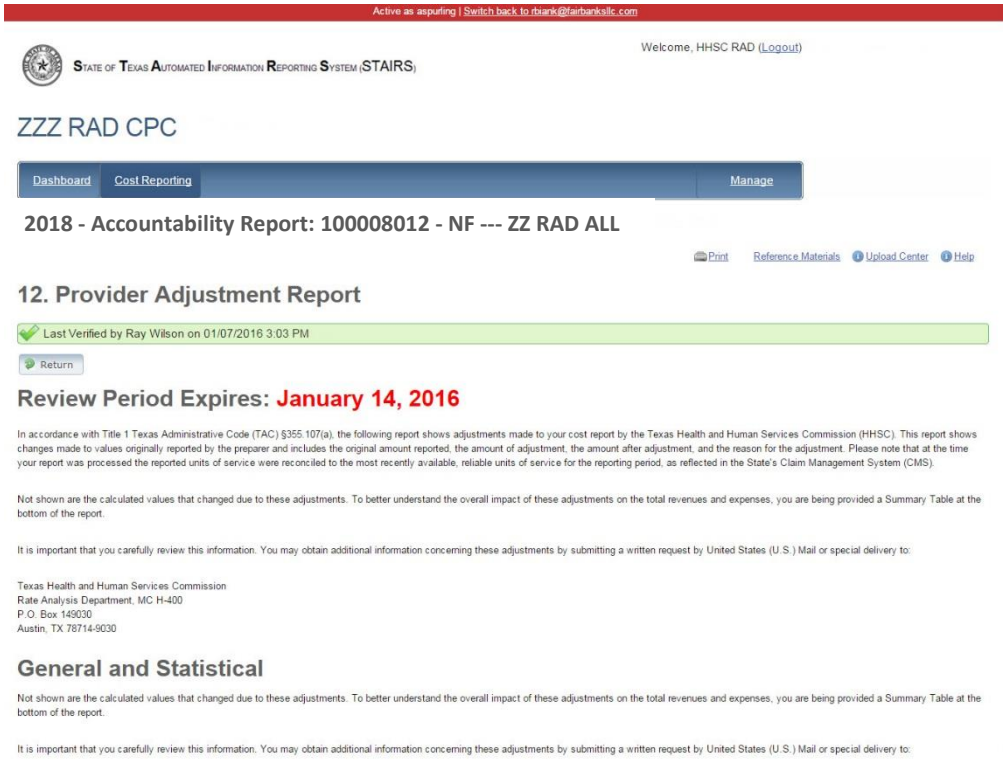
Notary Signature

Notary Public, State of

Commission Expires

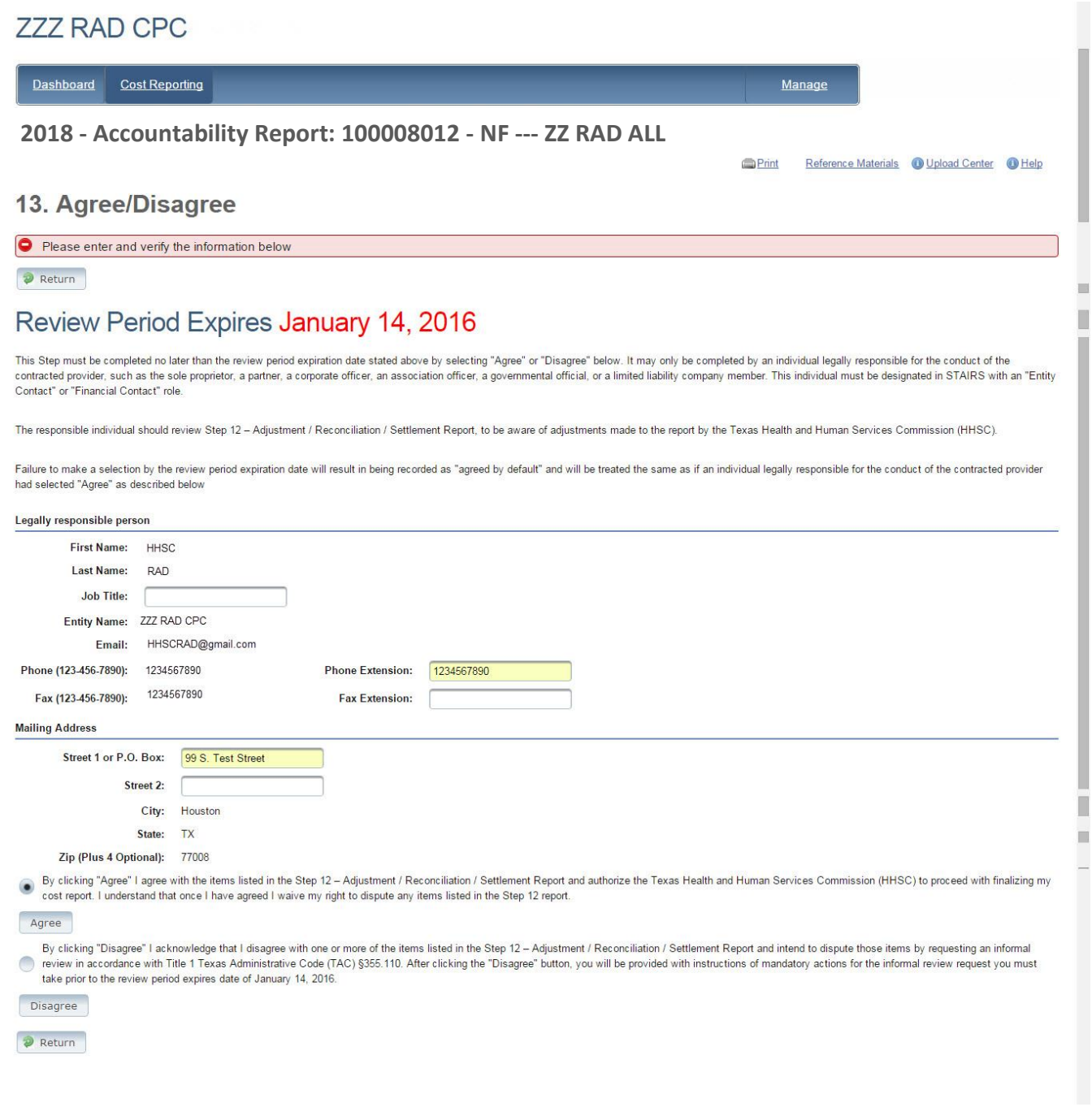
POST-AUDIT STEPS

Step 12 PROVIDER ADJUSTMENT REPORT



This Step will not be visible until after the report has been audited and provider is notified of adjustments to or exclusions of information initially submitted. Providers will receive e-mail notification that their adjustment report is ready. Provider then has 30 days within which to review their adjustments and go to ***Step 13*** to Agree or Disagree with the adjustments made. After the end of that 30-day period, the report will be set to the status of Agreed by Default

STEP 13 AGREE/DISAGREE



This Step will not be visible until after the report has been audited and provider is notified of adjustments to or exclusions of information initially submitted. The Step may only be completed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member. This individual must be designated in STAIRS with an "Entity Contact" or "Financial Contact" role.

This Step must be completed within the 30-day time frame from the date of the e-mail notifying the provider that ***Steps 12 and 13*** are available to the provider.

For providers with a recoupment amount above $25,000, the option "I Agree and Request a Payment Plan" will be available during Step 13. This option finalizes the report and requests a payment plan for paying the recoupment.

If a provider's cost report has a recoupment amount below $25,000, then the provider may still request a payment plan. The Rate Analysis Department has a formula that it uses to determine if a provider is eligible for a payment plan. However, each payment plan request will be determined on a case by case basis that considers the specific circumstances of the provider and the cost report.

Letters for a Payment Plan Request must be emailed to the Director of Rate Analysis for Long-Term Services and Supports at RAD-LTSS@hhsc.state.tx.us or by fax at (512) 730-7475 and must follow these requirements:

- Is on the company letterhead
- Details what is being requested (a payment plan)
- Includes the Cost Report Group number or Contract number of the report
- Includes the year and type of report (Cost Report 2018, for example)
- Is signed by the "an individual legally responsible for the conduct of the interested party, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable HHSC Enterprise or Texas Medicaid and Healthcare Partnership (TMHP) signature authority designation form for the interested party on file at the time of the request, or a legal representative for the interested party. The administrator or director of the facility or program is not authorized to sign the request unless the administrator or director holds one of these positions." Note that this is a person listed on DADS Form 2031 and is not necessarily the entity contact in STAIRS.
- The request meets the deadline, which is 30 days from the Provider Notification date

A provider who Disagrees with an adjustment is entitled to request an informal review of those adjustments with which the provider disagrees. A provider cannot request an informal review merely by signifying provider's Disagreement in ***Step 13***. The request, or a request for a 15-day extension to make the request, must be in writing and received by HHSC no later than the review period expiration date. Additionally, the request must include all necessary elements as defined in 1 TAC 355.110(c)(1).

STEP 14 HHSC INFORMAL REVIEW

This Step only appears if the provider submits a request for an informal review. It is used by HHSC to make adjustments during the informal review process. Provider will not be able to access this Step until HHSC notifies provider of that adjustments are ready to be viewed.

APPENDIX A – Uploading Documents into STAIRS

Accountability reports submitted without the required documentation will be returned to the provider as unacceptable. See 1 TAC §355.102(j)(2) and 1 TAC §355.105(b)(2)(B)(v).

All instructions for uploading documents into STAIRS and managing and attaching those documents electronically can be found in the STAIRS program by clicking on the Uploading File Instructions file under General Reference Materials at the bottom right hand corner of any screen in STAIRS. The Upload Center itself can be located in STAIRS on the Dashboard through clicking on Manage, to the far right on the header.

APPENDIX B – Allocation Methodologies

Square footage: This allocation method is the most reasonable for building and physical plant allocations.

Units of Service: This allocation method can only be used for shared costs where the services have equivalent units of equivalent service and MUST be used where that is the case. An equivalent unit means the time of a service is important: a Nursing Facility (NF) and a DAHS facility both provide a "Day" of service, but one is a 24-hour "Day" while the other is not. An equivalent service means that the activities provided by staff are essentially the same. If a provider has only NF facilities between which to allocate their shared administrative costs, then they MUST use the Units of Service method.

Labor costs: This allocation method can be used where all of a provider's contracts are labor intensive, or all contracts have a programmatic or residential-building cost, or contracts are mixed with some being labor intensive and others having a programmatic-building or residential-building component. It is calculated based upon the ratio of directly charged labor costs for each contract to the total directly charged labor costs for all contracts. The Five Cost Components of the Labor Costs Allocation Method:

- Salaries/Wages
- Payroll taxes
- Employee benefits/insurance
- Workers' compensation costs
- Contracted labor (excluding consultants)

Total cost less facility cost: The Total-Cost-Less-Facility-Cost allocation method can be used if a provider's contracts are mixed – some being labor-intensive and others having a programmatic or residential building component. This method can also be used for an organization that has multiple contracts all requiring a facility for service delivery. This method allocates costs based upon the ratio of each contract's total costs less that contract's facility or building costs to the provider's total costs less facility or building costs for all contracts

If any of these allocation methods are used, the allocation summary must clearly show that all the cost components of the allocation method have been used in the allocation calculations. For example, when describing the numerator and denominator in numbers for the salaries method, the numerator and denominator each should clearly show the amount of costs for salaries/wages and for contracted labor (excluding consultants).

Cost-to-Cost: If allocations based on units of service are not acceptable, and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs on a cost-to-cost basis. This method cannot be used by providers with both HCS and ICF/IID programs. The Cost-to-Cost method allocates costs based upon the percentage of each contract's directly charged costs to the total directly charged costs for all contracts. The cost-to cost method includes facility and operations costs.

Salaries: If allocation based on Units of Service is not acceptable, and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs on the basis of salaries. This method cannot be used by

providers with both The Salaries method allocates costs based upon the percentage of each contract's salaries to the total salaries for all contracts. The two cost components of the salaries allocation method:

- Salaries/wages
- Contracted labor (excluding consultants)

In the cost component above, the term "salaries" does not include the following costs associated with the salaries/wages of employees:

- Payroll taxes
- Employee benefits/insurance
- Workers' compensation

Functional: If the provider has any doubt whether the functional method used is in accordance with applicable rules or requires prior written approval from the Rate Analyst, contact the Rate Analyst prior to submitting the accountability report. Functional allocations include allocations of NF costs by use of attendance records, building square footage allocations, staff timesheets or vehicle mileage logs.

Time study: The time study must be in compliance with 1 TAC §355.105(b)(2)(B)(i). If the time study is not in compliance with these rules, the provider must receive written approval from the Rate Analyst to use the results of the time study. According to the rules, a time study must cover, at a minimum, one randomly selected week per quarter throughout the reporting period. The allocation summary should include the dates and total hours covered by the time study, as well as a breakdown of the hours time-studied by function or business component, as applicable.

Other allocation method approved by HHSC: Requests for approval to change an allocation method or to use an allocation method other than an allocation method approved or allowed by HHSC must be received by HHSC's Rate Analysis Department before the end of the provider's fiscal year, as described at 1 TAC §355.102(j)(1)(D). To request such approval from HHSC Rate Analysis, submit and properly a disclosure statement along with justification for the change and explain how the new allocation method is in compliance with the Cost Determination Process Rules and how the new allocation method presents a more reasonable representation of actual operations.

If using an alternate allocation method, upload a properly cross-referenced copy of the provider's original allocation method approval request and any subsequent approval letter from Rate Analysis. If the provider's approval request included examples or a copy of the provider's general ledger, include those documents in the uploaded attachments for this item.

Table 1 below provides a summary of appropriate allocation methods for various situations. For questions regarding proper allocation of shared costs, please contact the Rate Analyst.

TABLE 1. APPROPRIATE ALLOCATION METHODS FOR REPORTING SHARED ADMINISTRATIVE COSTS THAT CANNOT BE REASONABLY DIRECT COSTED

Makeup of Controlling Entity's Business Components	Multiple Contracts of the Same (Equivalent) Type of Service	Various Business Components - All Labor-Intensive	Various Business Components - All with Programmatic- or Residential-Building Costs	Mixed Business Components - Some with Programmatic- or Residential-Building Costs and Some Labor-Intensive	Shared Administrative Personnel Performing Different Duties for Different Business Components (not in Direct Care)	Functional Methods
Allowable Allocation Methods	Units of Service	Cost-to-Cost Labor Costs Salaries **Not applicable to NF providers**	Cost-to-Cost Total-Cost-Less-Facility-Cost^ Labor Costs Salaries	Total-Cost-Less-Facility-Cost^ Labor Costs	Time Study*	Payroll Department - Number of payroll checks issued for each business component during the reporting period Purchasing Department - Number of purchase orders processed during the reporting period for each business component

Providers may use any of the methods listed as appropriate for the makeup of their business organization. If one of the approved methods does not provide a reasonable reflection of the provider's actual operations, the provider must use a method that does. If none of the listed methods provides a reasonable reflection of the provider's actual operations, contact the Rate Analyst for further instructions.

* See 1 TAC §355.105(b)(2)(B)(i) for time study requirements.

^ When using the total-cost-less-facility-cost allocation method, the building (facility) costs to be removed from the cost calculation include Lease/Rental of Building/Facility/Building Equipment; Insurance for those items; Utilities, Maintenance and Contract Services of those items; Mortgage Interest; Ad Valorem Taxes; and Depreciation for Building/Facility/Building Equipment/Land/Leasehold Improvements

Allocation Summary - UNITS of SERVICE

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

Expenses:	Total Costs	Disallowed	Direct Costs NF 1	Direct Costs NF 2	Shared Costs	Allocated Shared Costs 55.69% NF 1	Allocated Shared Costs 44.31% NF 2	Line Item NF 1	Line Item NF 2
Salaries									
Direct Care Nursing Staff	125,347.28				125,347.28	69,805.90	55,541.38	xxx	xxx
Dietary Staff	45,288.47		25,361.54	19,926.93	-	-	-	xxx	xxx
Administrative Staff	33,254.88		25,458.97	7,795.91	-	-	-	xxx	xxx
Housekeeping Staff	82,588.92		51,205.13	31,383.79	-	-	-	xxx	xxx
Contracted RN	65,000.00				65,000.00	36,198.50	28,801.50	xxx	xxx
FICA/Medicare	21,915.69		7,804.96	4,521.66	9,589.07	5,340.15	4,248.92	xxx	xxx
State & Federal Unemployment	5,156.63		1,270.51	554.46	3,331.66	1,855.40	1,476.26	xxx	xxx
Workers's Compensation	0.00		0.00	0.00	-	-	-	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	2,703.77	1,505.73	1,198.04	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	4,500.00	2,506.05	1,993.95	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	4,472.84	2,490.92	1,981.91	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	2,272.73	1,265.68	1,007.05	xxx	xxx
Office Supplies	1,501.80				1,501.80	836.35	665.45	xxx	xxx
Medical Supplies	874.64				874.64	487.09	387.55	xxx	xxx
Insurance - General Liability	1,254.00				1,254.00	698.35	555.65	xxx	xxx
Insurance - Malpractice	1,050.87				1,050.87	585.23	465.64	xxx	xxx
Travel	387.98	237.65	54.36	35.74	60.23	33.54	26.69	xxx	xxx
Advertising	402.87	104.97			297.90	165.90	132.00	xxx	xxx
Miscellaneous	601.47	254.74			346.73	193.09	153.64	xxx	xxx
Totals	410,426.58	597.36	117,596.68	69,629.03	222,603.51	123,967.90	98,635.62		

Units of Service Allocation Percentages:	Units of Service	Percentage
Total Healthy Care Units NF 1	9,961	55.69%
Total Healthy Care Units NF 2	7,924	44.31%
	17,885	100.00%

Allocation Summary - LABOR COST METHOD

Adjusted Trial Balance - Healthy Care Provider , Inc.
As of 12/31/20XX

Expenses:	Total Costs	Disallowed	Direct Costs NF1	Direct Costs NF2	Direct Costs Home Health	Shared Costs	Allocated Shared Costs 43.04% NF1	Allocated Shared Costs 30.36% NF2	Allocated Shared Costs 26.60% Home Health	Line Item NF1	Line Item NF2	Line Item Home Health
Salaries												
Direct Care Staff	125,347.28					125,347.28	53,949.47	38,055.43	33,342.38	xxx	xxx	xxx
Dietary Staff	87,434.22		87,434.22			-	-	-	-	xxx	xxx	xxx
Housekeeping Staff	65,238.41			65,238.41		-	-	-	-	xxx	xxx	xxx
Physical Therapists	54,975.15				54,975.15	-	-	-	-	xxx	xxx	xxx
Supervisors	33,254.88		13,528.48	9,467.85	10,258.55	-	-	-	-	xxx	xxx	xxx
Maintenance Staff	4,572.08	Labor	4,572.08			-	-	-	-	xxx	xxx	xxx
CPR Instructor	2,500.00	Costs				2,500.00	1,076.00	759.00	665.00	xxx	xxx	xxx
FICA/Medicare	28,018.12		8,073.41	5,715.03	4,990.38	9,239.30	3,976.59	2,805.05	2,457.65	xxx	xxx	xxx
State & Federal Unemployme	6,592.50		2,524.07	1,494.13	978.51	1,595.79	686.83	484.48	424.48	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	579.04	408.45	357.87	xxx	xxx	xxx
Workers' Compensation	0.00					-	-	-	-	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	860.80	607.20	532.00	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	855.61	603.54	528.79	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	739.58	521.69	457.08	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	646.37	455.95	399.48	xxx	xxx	xxx
Medical Supplies	874.64				487.39	387.25	166.67	117.57	103.01	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	452.29	319.04	279.53	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	3.56	2.51	2.20	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	128.22	90.44	79.24	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	149.23	105.27	92.23	xxx	xxx	xxx
Totals	438,553.35	564.36	122,627.82	87,361.70	78,672.64	149,326.83	64,270.27	45,335.63	39,720.94			

Labor Method Allocation Percentages:	Labor Costs	Percentage
Total Healthy Care NF1	117,386.27	43.04%
Total Healthy Care NF2	82,804.89	30.36%
Total Healthy Care Home Health	72,561.00	26.60%

Allocation Summary - **TOTAL COST LESS FACILITY COST**

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

			Direct Costs			Allocated Shared Costs			
				Adult Day Care	Shared	57.22%	42.78%	Line Item	
Expenses:	Total Costs	Disallowed	NF1	DAHS	Costs	NF1	DAHS	NF1	DAHS
Salaries									
Administrative	125,347.28				125,347.28	71,723.71	53,623.57	xxx	xxx
Direct Care Staff	87,434.22		87,434.22		-	-	-	xxx	xxx
Adult Day Care Attendants	33,254.88			33,254.88	-	-	-	xxx	xxx
Adult Day Care Drivers	25,492.12			25,492.12	-	-	-	xxx	xxx
Contracted Nurse	9,482.66			9,482.66	-	-	-	xxx	xxx
FICA/Medicare	18,821.78		8,843.84	5,219.57	4,758.37	2,722.74	2,035.63	xxx	xxx
State & Federal Unemployment	4,428.65		2,822.33	665.10	941.23	538.57	402.66	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	2,703.77	1,547.10	1,156.67	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	4,500.00	2,574.90	1,925.10	xxx	xxx
Utilities	8,945.67	Facility	2,385.51	2,087.32	4,472.84	2,559.36	1,913.48	xxx	xxx
Ad Valorem Taxes	3,256.88	Costs	842.64	1,834.64	579.60	331.65	247.95	xxx	xxx
Maintenance & Repairs	1,846.74		246.25	1,041.67	558.82	319.76	239.06	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	2,272.73	1,300.46	972.27	xxx	xxx
Office Supplies	1,501.80				1,501.80	859.33	642.47	xxx	xxx
Medical Supplies	874.64				874.64	500.47	374.17	xxx	xxx
Insurance - General Liability	1,254.00				1,254.00	717.54	536.46	xxx	xxx
Insurance - Malpractice	1,050.87				1,050.87	601.31	449.56	xxx	xxx
Travel	387.98	237.65	54.36	35.74	60.23	34.46	25.77	xxx	xxx
Advertising	402.87	104.97			297.90	170.46	127.44	xxx	xxx
Miscellaneous	601.47	254.74			346.73	198.40	148.33	xxx	xxx
Totals	341,239.93	597.36	106,684.84	82,436.92	151,520.81	86,700.21	64,820.60		

Total Costs-Less-Facility-Costs Allocation Percentages:

	NF1	DAHS	Totals
Total Healthy Care Costs	106,684.84	82,436.92	189,121.76
Total Healthy Care Facility Costs	5,874.40	7,063.63	12,938.03
Total Healthy Care Costs Less Facility Costs	100,810.44	75,373.29	176,183.73

Allocation Summary - COST-TO-COST

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

				Direct Costs		Shared	Allocated Shared Costs 41.48%	30.72%	27.80%	Line Item		
Expenses:	Total Costs	Disallowed	NF1	DAHS	PHC	Costs	NF1	DAHS	PHC	NF1	DAHS	PHC
Salaries												
Administrative	125,347.28					125,347.28	51,994.05	38,506.68	34,846.54	xxx	xxx	xxx
CBA Attendants	87,434.22		87,434.22			-	-	-	-	xxx	xxx	xxx
CLASS Habilitation Attendants	65,238.41			65,238.41		-	-	-	-	xxx	xxx	xxx
PHC Attendants	54,975.15				54,975.15	-	-	-	-	xxx	xxx	xxx
Supervisors	33,254.88		13,528.48	9,467.85	10,258.55	-	-	-	-	xxx	xxx	xxx
Speech Therapists	249.85		249.85			-	-	-	-	xxx	xxx	xxx
CPR Instructor	2,500.00					2,500.00	1,037.00	768.00	695.00	xxx	xxx	xxx
FICA/Medicare	28,018.12		7,723.65	5,715.03	5,009.49	9,569.95	3,969.62	2,939.89	2,660.45	xxx	xxx	xxx
State & Federal Unemployment	6,592.50		2,524.07	1,494.13	978.51	1,595.79	661.93	490.23	443.63	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	558.06	413.29	374.01	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	829.60	614.40	556.00	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	824.59	610.69	552.64	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	712.78	527.88	477.70	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	622.95	461.35	417.50	xxx	xxx	xxx
Medical Supplies	874.64				874.64	-	-	-	-	xxx	xxx	xxx
Insurance - General Liability	1,254.00					1,254.00	520.16	385.23	348.61	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	435.90	322.83	292.14	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	3.43	2.54	2.30	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	123.57	91.51	82.82	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	143.82	106.52	96.39	xxx	xxx	xxx
Totals	435,485.12	564.36	117,955.83	87,361.70	79,079.00	150,524.23	62,437.45	46,241.04	41,845.74			

Cost-to-Cost Allocation Percentages:	Total Costs	Percentage
Total Healthy Care NF1	117,955.83	41.48%
Total Healthy Care DAHS	87,361.70	30.72%
Total Healthy Care PHC	79,079.00	27.80%

Allocation Summary - SALARIES METHOD

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

			Direct Costs				Allocated Shared Costs			Line Item		
Expenses:	Total Costs	Disallowed	NF1	NF2	DAHS	Shared Costs	22.87% NF1	50.59% NF2	26.54% DAHS	Lake NF1	River NF2	Ocean DAHS
Salaries												
Administrative	125,347.28					125,347.28	28,666.92	63,413.19	33,267.17	xxx	xxx	xxx
Direct Care Staff	87,434.22		19,286.35	46,289.32	21,858.55	-	-	-	-	xxx	xxx	xxx
Drivers	44,295.84		10,352.45	22,576.36	11,367.03	-	-	-	-	xxx	xxx	xxx
Housekeeping Staff	54,975.15	Salary	12,094.53	29,136.83	13,743.79	-	-	-	-	xxx	xxx	xxx
Contracted RN	70,000.00		15,299.99	28,145.20	19,221.57	7,333.24	1,677.11	3,709.89	1,946.24	xxx	xxx	xxx
Dietitian	2,400.00					2,400.00	548.88	1,214.16	636.96	xxx	xxx	xxx
FICA/Medicare	28,018.12		7,723.65	5,715.03	5,009.49	9,569.95	2,188.65	4,841.44	2,539.86	xxx	xxx	xxx
State & Federal Unemployment	6,592.50		2,524.07	1,494.13	978.51	1,595.79	364.96	807.31	423.52	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	307.68	680.62	357.06	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	457.40	1,011.80	530.80	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	454.64	1,005.69	527.60	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	392.99	869.32	456.05	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	343.46	759.76	398.58	xxx	xxx	xxx
Medical Supplies	874.64				487.39	387.25	88.56	195.91	102.78	xxx	xxx	xxx
Insurance - General Liability	1,254.00					1,254.00	286.79	634.40	332.81	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	240.33	531.64	278.90	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	1.89	4.18	2.19	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	68.13	150.71	79.06	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	79.30	175.41	92.02	xxx	xxx	xxx
Totals	450,937.82	564.36	73,776.60	138,803.15	79,648.99	158,144.72	36,167.70	80,005.41	41,971.61			

Salary Method Allocation Percentages:	Salary Costs	Percentage
Total Healthy Care NF1	57,033.32	22.87%
Total Healthy Care NF2	126,147.71	50.59%
Total Healthy Care DAHS	66,190.94	26.54%

APPENDIX C - Allocation of Shared Dietary/Central Kitchen

Allocation of Shared Dietary/Central Kitchen Expenses

A central kitchen is defined as a kitchen that provides meals and/or snacks to more than one contract, program, or business entity. If the provider has a central kitchen that prepares meals for more than one business entity or program, do not report the expense of the meals provided for this entity as a single entry on the accountability report. Shared dietary/central kitchen expenses must be reported on the accountability report in the various items that reflect the types of expense (i.e. building depreciation, salaries, food, food service supplies).

Shared dietary/central kitchen costs include dietary staff costs, food costs, nonfood supplies, contracted dietary services, kitchen building costs (including depreciation/lease, maintenance costs, utilities, insurance, and other facility costs allocable to the kitchen area), and kitchen departmental equipment costs (including non-depreciable purchases, depreciation, rental/lease costs, and repairs/maintenance costs). If the dining room is also shared, then the dining room costs (i.e., staff, building, and departmental equipment) must also be properly allocated.

If dietary staff work in positions other than the kitchen area, the time spent working in each function must be documented and properly reported using continuous, daily timesheets. The non-dietary staff costs must be first removed before applying an allocation method to the shared dietary/central kitchen costs.

Allocation of these expenses must be accompanied by a detailed allocation summary. Accountability reports that are submitted without the required detailed summaries will not be considered acceptable and will be returned for proper completion. (Refer to 1 TAC §355.102(j) and 1 TAC §355.105(b)(2)(B)(v))

Central kitchen costs can be allocated based on one of three functional allocation methods:

- Number of meals provided;
- The weighted number of meals provided; or
- Central kitchen allocation methodology guidelines.

NUMBER OF MEALS PROVIDED ALLOCATION METHOD

All shared dietary/central kitchen costs can be allocated by the number of meals provided allocation method if the central kitchen:

1. Prepares meals for only one Medicaid program (e.g. NF); and
2. Provides the same meal service to all the contracts in that Medicaid program, such as:
   a. Breakfast, lunch, dinner and two snacks to all NF contracts, or
   b. Breakfast, lunch and dinner to all NF contracts, or
   c. Breakfast, lunch, dinner and one snack to all NF contracts.

There are certain situations where using the number of meals provided as an allocation basis for central kitchen expenses is not appropriate. The following situations are examples where the number of meals provided is **not** an acceptable allocation method:

A central kitchen provides meals to different types of Medicaid programs. For example:

a. The central kitchen provides meals to an ICF/IID component and to a Nursing Facility contract; or
b. The central kitchen provides meals to multiple components/contracts of the same Medicaid program, but some of the components/contracts receive breakfast, lunch, dinner and two snacks, and other components/contracts receive only lunch and dinner and one snack, or breakfast, lunch and dinner and no snacks.

When the meals service is not the same and dietary care services are shared by more than one business component (e.g., ICF/IID, NF, child day care, and/or hospital), the shared dietary costs must be properly allocated using either of the following allocation methods:

- The Weighted Number of Meals Provided Allocation Method or
- The Central Kitchen Allocation Methodology Guidelines

WEIGHTED NUMBER OF MEALS PROVIDED ALLOCATION METHOD

The "weighted number of meals provided" method of allocating meal costs uses United States Department of Agriculture (USDA) Child and Adult Care Food Program meals patterns and child-to-adult meals ratios to develop weights for each type of meal (i.e., breakfast, lunch, dinner, and snack) for different age groups (i.e., children ages 3 to 5, children ages 6 to 12, and adults). These weights can then be used to determine the proportion of total weighted meals provided by the central kitchen to each age group and to each NF contract. By multiplying the proportion of total weighted meals provided to the NF contract for which the accountability report preparer is completing the accountability report by the various central kitchen costs, the accountability report preparer can determine the central kitchen costs which should be reported on this accountability report.

The weights for each meal type for each age group are calculated by multiplying the child-to-adult ratio for the age group and meal type by the Recommended Daily Allowance (RDA) weight for the age group and meal type. These weights are calculated in Tables 1 – 3 below followed by examples of the calculation of ratios for meals served only to adults with different meal service (Example 1) and the calculation of ratios for meals served to both adults and children (Example 2).

Table 1. Meal Weights for Children Ages 3 to 5.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	0.6667	X	0.75	=	0.5000
Lunch	0.5625	X	1.00	=	0.5625
Snack	0.7500	X	0.50	=	0.3750
Supper	0.5625	X	1.00	=	0.5625

Table 2. Meal Weights for Children Ages 6 to 12.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	0.8333	X	0.75	=	0.6250
Lunch	0.8125	X	1.00	=	0.8125
Snack	1.2500	X	0.50	=	0.6250
Supper	0.8125	X	1.00	=	0.8125

Table 3. Meal Weights for Adults.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	1.00	X	0.75	=	0.75
Lunch	1.00	X	1.00	=	1.00
Snack	1.00	X	0.50	=	0.50
Supper	1.00	X	1.00	=	1.00

Example 1. The Weighted Number of Meals Provided Allocation Method -
Calculation of Ratios for Meals Served Only to Adults With Different Meal Service
(This allocation method is to be used when a central kitchen serves only adults.)

A central kitchen provides meals to an NF and a Day Activity and Health Services (DAHS) program which both serve only adults. The provider maintained meal counts on both programs.

DAHS	RDA Weight	Meal Count	Weighted Meal Count (rounded to 2 decimals)
Morning Snack	0.5	15,621	7,810.50
Lunch	1	15,608	15,608.00
Afternoon Snack	0.5	14,527	7,263.50
Total weighted meals			30,682.00

NF	RDA Weight	Meal Count	Weighted Meal Count (rounded to 2 decimals)
Breakfast	0.75	7,851	5,888.25
Lunch	1	7,803	7,803.00
Morning Snack	0.5	7,474	3,737.00
Dinner	1	6,352	6,352.00
Afternoon Snack	0.5	6,498	3,249.00
Total weighted meals			27,029.25

Allocation percentage based on the weighted meals count.

	Weighted Meals Count	Percentage for Allocation
DAHS	30,682.00	53.16%
NF	27,029.25	46.84%
Total	57,711.25	100.00%

Allocation of Shared Dietary Expenses	Total	DAHS	NF
Central kitchen costs to be allocated:	100.00%	53.16%	46.84%
Raw food costs	$94,934.70	$50,467.29	$44,467.41
Cook Salary	$17,680.00	$9,398.69	$8,281.31
Assistant Salary	$10,712.00	$5,694.50	$5,017.50
Building Rent	5,993.20	$3,185.99	$2,807.21
Building Insurance	$1,020.26	$542.37	$477.89
Utilities	$3,049.66	$1,621.20	$1,428.46
Pest Control	$151.44	$80.51	$70.93
Equipment	$55.30	$29.40	$25.90
Non-Food Supplies	$295.68	$157.18	$138.50
Total central kitchen costs to be allocated:	$133,892.24	$71,183.38	$62,708.86

Example 2. The Weighted Number of Meals Provided Allocation Method -
Calculation of Ratios of Meals Served to Both Adults and Children
(This allocation method is to be used when a central kitchen serves both children and adults).
A central kitchen provides meals to three different programs: a day care that serves children 3-5 years old; a day care that serves to children 6-12 years old; and a NF that serves only adults. The provider kept meal counts on each of the three programs.

a. Total Meal Count

	Day Care 3-5 yrs. old	Day Care 6-12 yrs. old	NF Adults
Breakfast	5,200	3,900	0
Snack	0	0	7,800
Lunch	5,200	3,900	7,800
Snack	5,200	3,120	6,500
Dinner	5,200	0	0

b. Weighted Meal Count for Day Care (3-5 yrs. old)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.5000	5,204	2,602.00
Snack	0.3750	0	0.00
Lunch	0.5625	5,200	2,925.00
Snack	0.3750	5,200	1,950.00
Supper	0.5625	5,200	2,925.00
Total			10,402.00

c. Weighted Meal Count for Day Care (6-12 yrs. old)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.620	3,900	2,438.00
Snack	0.6250	0	0.00
Lunch	0.8125	3,900	3,168.75
Snack	0.6250	3,120	1,950.00
Dinner	0.8125	0	0.00
Total			7,556.75

d. Weighted Meal Count for NF (Adults)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.75	0	0.00
Snack	0.5	7,800	3,900.00
Lunch	1	7,800	7,800.00
Snack	0.5	6,500	3,250.00
Dinner	1	0	0.00
Total			14,950.00

* = rounded to two decimal places.

e. Allocation percentage based on the weighted meal count

Program	Wtd Meal Count	% for Allocation
Day Care (3-5 yrs. old)	10,402.00	31.61%
Day Care (6-12 yrs. old)	7,556.75	22.96%
NF	14,950.00	45.43%
TOTAL	32,908.75	100.00%

f. Allocation of Shared Dietary Expenses	Total	3-5 yrs.	6-12 yrs.	NF
Central kitchen costs to be allocated:	100.00%	31.61%	22.96%	45.43%
Raw food costs	$94,934.70	$30,008.86	$21,797.01	$43,128.83
Cook Salary	$17,680.00	$5,588.65	$4,059.33	$8,032.02
Assistant Salary	$10,712.00	$3,386.06	$2,459.48	$4,866.46
Building Rent	5,993.20	$1,894.45	$1,376.04	$2,722.71
Building Insurance	$1,020.26	$322.50	$234.25	$463.50
Utilities	$3,049.66	$964.00	$700.20	$1,385.46
Pest Control	$151.44	$47.87	$34.77	$68.80
Equipment	$55.30	$17.48	$12.70	$25.12
Non-Food Supplies	$295.68	$93.46	$67.89	$134.33
Total Central kitchen costs to be allocated:	$133,892.24	$42,323.34	$30,741.66	$60,827.24

CENTRAL KITCHEN ALLOCATION METHOD

All shared dietary/central kitchen costs can be allocated by the Central Kitchen Allocation Method if the provider believes that this method gives a more accurate picture of the true allocation of their central kitchen costs then either the Number of Meals Provided Allocation Method (if appropriate) and the Weighted Number of Meals Provided Allocation Method.

Section 1-Introduction

The actual cost of preparing each type of meal or snack must be determined, by completing a raw food cost survey and a meal preparation time study. The minimum period of time to be used for each of these must be the time it takes to complete a menu cycle. A menu cycle is defined as the period of time it takes to have the menu repeat, whether it is two weeks, a month, or some other period of time. If the menu or the menu cycle changes substantially (i.e., if child day care meals are different during the school year from the summer months), a new raw food cost survey and a new meal preparation time study are required to be completed.

Note that this example assumes that the noon meal for an individual receiving DAHS services and an individual receiving NF services is the same in content and portion size. If a particular meal requirement is not the same in content and/or portion size, as in the case of an individual receiving DAHS services and a child in day care, the meals must be tracked separately.

Section 2-Determining Food Costs by the Completion of a Raw Food Cost Survey

(A) For the menu cycle period of time, track and direct charge raw food costs to each type of meal and snack prepared for each type of program or business entity. This should be done on a daily basis. Total the costs for each type of meal or snack for the menu cycle period of time. In this example, the menu cycle is from April 1, 2009 through April 30, 2009.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Raw Food Costs *	$445.90	$1,549.10	$6,001.36	$351.20	$2,499.03	$303.91	$11,150.50

(B) The raw food cost, for the menu cycle period of time, for each type of meal and snack is then used to calculate a percentage. Calculate the percentages by determining the ratio of the raw food costs for each type of meal and snack to the total raw food costs for all meals and snacks.

Percentage of Total	4.00%	13.89%	53.82%	3.15%	22.41%	2.73%	100.00%

(C) Allocate total raw food costs for the provider's cost-reporting period to each type of meal and snack by the raw food cost percentages calculated above in (B). In this example, the total raw food costs for the cost-reporting period as reflected on the provider's trial balance are $94,934.70.

Raw Food Costs for Reporting Period	$3,797.39	$13,186.43	$51,093.85	$2,990.44	$21,274.87	$2,591.72	$94,934.70

* These raw food costs should be supported by daily worksheet calculations which reflect the actual cost determined for each type of meal and/or snack. Raw food costs should be documented by food invoices and other supporting documentation.

Section 3-Determining Staff Costs by the Completion of a Meal Preparation Time Study

(A) For the menu cycle period of time, record the time spent by each staff person involved in the preparation of the meals and snacks by each type of meal and snack prepared. The timesheets should be kept in time increments of 30 minutes or less and should be kept on a daily basis during the menu cycle period of time. Total the time spent preparing each type of meal or snack for the menu cycle period of time. These totals should reflect the direct meal preparation time. Do not include in these totals the indirect time spent by staff (breaks, lunches, shopping, meetings, etc.); only include the direct meal preparation time. Total central kitchen staff salaries (direct and allocated) will be allocated based on the direct meal preparation time.

(B) For each staff person, use the time spent per meal and snack from (A) to calculate the percentage of the time spent on the preparation of each type of meal and snack. Calculate the percentages by determining the ratio of the time spent on each meal and snack to the total time spent on all meals and snacks.

(C) Multiply each staff person's total salary, payroll taxes, and benefits (PTB), as reflected in the provider's payroll records for the cost-reporting period, by the percentages calculated in (B) to each type of meal and snack.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Cook Hours**	20.50	19.25	40.00	10.75	39.25	10.50	140.25
Percentage of Hours	14.62%	13.73%	28.52%	7.66%	27.98%	7.49%	100.00%
Cook Salary, PTB for Cost-Reporting Period	$2,584.82	$2,427.46	$5,042.34	$1,354.29	$4,946.86	$1,324.23	$17,680.00
Assistant Hours **	14.25	13.50	39.00	15.75	39.75	13.25	135.50
Percentage of Hours	10.52%	9.96%	28.78%	11.62%	29.34%	9.78%	100.00%
Assistant Salary, PTB for Cost-Reporting Period	$1,126.90	$1,066.92	$3,082.91	$1,244.74	$3,142.90	$1,047.63	$10,712.00

Section 4 - Using Staff Hours to Determine Utilization

Total the hours collected during the menu cycle period of time for all staff by type of meal and snack. Calculate the percentage of the total time spent on the preparation of each type of meal and snack by determining the ratio of the time spent on each type of meal and snack to the total time spent on all meals and snacks during the period covered by the meal preparation time study.

Total Staff Hours	34.75	32.75	79.00	26.50	79.00	23.75	275.75
Percentage of Total Staff Hours	12.60%	11.88%	28.65%	9.61%	28.65%	8.61%	100.00%

** These amounts of time should be supported by daily timesheets which reflect the direct charge to each type of meal and/or snack.

Section 5 - Identifying Other Central Kitchen Costs

(A) For the provider's cost-reporting period, all central kitchen costs (other than food and staff costs) must be identified. These include, but are not limited to:

- Building costs, such as rent or depreciation, building insurance, utilities, maintenance, or mortgage interest. These building costs can be allocated to the central kitchen based on square footage.
- The cost/depreciation of kitchen equipment and appliances, such as refrigerators, stoves, etc.
- Costs of drivers and vehicles used to deliver the meals.
- Other related non-food costs such as kitchen supplies.

Central Kitchen Costs:

Building rent	$5,993.20
Building insurance	$1,020.26
Utilities	$3,049.66
Pest Control	$151.44
Equipment	$55.30
Non-Food Supplies	$295.68
Total Other Central Kitchen (CK) Costs	$10,565.54

(B) The other central kitchen costs identified in (A) above will be allocated to each type of meal and snack based on staff utilization (i.e., based on staff hours).

Apply the percentages which were calculated Section 2 to the other central kitchen costs identified above to allocate them to each type of meal and snack.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Percentage of Total Hours	12.60%	11.88%	28.65%	9.61%	28.65%	8.61%	100.00%
Other Central Kitchen Costs	$1,331.25	$1,255.19	$3,027.03	$1,015.35	$3,027.03	$909.69	$10,565.54

Section 6 - Determining Cost Per Meal and Allocated Central Kitchen Costs

(A) Sum all costs of providing meals as calculated is Sections 2-5.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Raw Food Costs (Section 1)	$3,797.39	$13,186.43	$51,093.85	$2,990.44	$21,274.87	$2,591.72	$94,934.70
Cook Salary (Section 3)	$2,584.82	$2,427.46	$5,042.34	$1,354.29	$4,946.86	$1,324.23	$17,680.00
Assistant Salary (Section 3)	$1,126.90	$1,066.92	$3,082.91	$1,244.74	$3,142.90	$1,047.63	$10,712.00
Other Central Kitchen Costs (Section 5)	$1,331.25	$1,255.19	$3,027.03	$1,015.35	$3,027.03	$909.69	$10,565.54
Total Central Kitchen Costs	$8,840.36	$17,936.00	$62,246.13	$6,604.82	$32,391.66	$5,873.27	$133,892.24

(B) Divide the actual numbers of meals/snacks prepared during the cost-reporting period into the costs for each type of meal and snack as calculated in (A) above to determine an individual meal or snack cost.

Total Meals and Snacks***	15,621	7,851	23,411	22,001	6,352	6,498	81,734
Cost per Meal/Snack	$0.5660	$2.2845	$2.6588	$0.3002	$5.0994	$0.9039	

(C) The actual number of meals/snacks prepared for ach contract during the cost-reporting period is multiplied by the cost per meal or snack calculated in (B) above. Those costs are totaled by contract.

Actual Number of Meals and Snacks Provided:							
Adult Day Care (DAHS)	15,621		15,608	14,527			
NF		7,851	7,803	7,474	6,352	6,498	
Total Central Kitchen Costs:							
Adult Day Care (DAHS)	$8,841.49		$41,498.55	$4,361.01			$54,701.05
NF		$17,935.61	$20,746.62	$2,243.69	$32,391.39	$5,873.54	$79,190.85

DAHS Central Kitchen Costs: To be reported on DAHS Accountability report $54,701.00

NF To be reported on NF Accountability report $79.191.00

*** The number of meals and snacks provided should be supported by daily worksheets.

(D) Develop the allocation percentages (to two decimals places) based on each program's total costs to the total of all programs total costs:

Shared Dietary Methodology Allocation Percentages:	Dietary Costs	Percentage
Total DAHS	$54,701.00	40.85%
Total NF	$79,191.00	59.15%
Total all programs	$133,892.00	100.00%

(E) Apply the allocation percentages developed in (D) above to all the central kitchen costs to allocate to the appropriate line item:

		Allocated Shared Costs	
		40.85%	59.15%
Shared Dietary Expenses:	Amount	DAHS	NF
Raw Food Costs	$94,934.70	38,780.82	56,153.88
Cook Salary	$17,680.00	7,222.28	10,457.72
Assistant Salary	$10,712.00	4,375.85	6,336.15
Building rent	$5,993.20	2,448.22	3,544.98
Building insurance	$1,020.26	416.78	603.48
Utilities	$3,049.66	1,245.79	1,803.87
Pest Control	$151.44	61.86	89.58
Equipment	$55.30	22.59	32.71
Non-Food Supplies	$295.68	120.79	174.89
Totals	$133,892.24	54,694.98	79,197.26

APPENDIX D - A List of Some Useful Lives for Depreciation

STAIRS will assign useful lives based on data input in ***Step 8e***. Provided below is an abbreviated list of some useful lives as stated in the American Hospital Association's 2008 guide (in alphabetical order from left to right). Refer to the AHA publication for items not listed. The 2008 guide is effective for depreciable assets placed in service during the 2008 and subsequent fiscal years. Depreciable assets place in service prior to the 2008 fiscal year should follow the guide in effect at the time or the 1993 guide.

Buildings .....30 yrs
Building Additions.....30 yrs
Cars and Minivans .....3 yrs
Light Trucks & Vans.....5 yrs
Buses and Airplanes .....7 yrs
Used Vehicles - see 1 TAC §355.103(b)(10)(C)(ii)

Asset	*Years*
Air Conditioning-5 tons or more	10
Apnea Monitor	7
Bed - Flotation Therapy	10
Bed - Manual	15
Bench - Metal or Wood	15
Breathing Unit - Positive Pressure	8
Camera - Video Tape	5
Chair - Geriatric	10
Chair - Shower/Bath	10
Computer - Laptop	3
Computer - Printer	5
Cooler - walk-in	15
Desk - Metal or Wood	20
Dresser	15
Emergency Generator	20
Fencing - Brick or Stone	25
Fencing - Wood	8
Flooring - Carpet	5
Flooring - Vinyl	10
Guard Rails	15
Intercom System	10
Lawn and Patio Furniture	5
Nurses' Counter - Built In	15
Oxygen Tank, Motor, and Truck	8
Paving - Asphalt	8
Photocopier - Large	5
Pump - Infusion	10
Refrigerator - Commercial	10
Shrubs and Lawns	5
Table - Food Prep	15
Table - Wood	15
Television	5
VCR	5
Wheelchair	5

Asset	*Years*
Air Conditioning System - Less than 5 tons	5
Bath - Whirlpool	10
Bed - Electric	12
Beepers - Paging	3
Bookcase - Metal or Wood	20
Cabinet	15
Cart	10
Chair - Guest	15
Chart Rack	20
Computer - Personal	3
Computer - Software	3
Curtains and Drapes	5
Dishwasher	10
Dryer - Clothes	10
Fax Machine	3
Fencing - Chain Link	15
Files - Regular	15
Flooring - Ceramic	20
Food Service Furniture	15
Housekeeping Furniture	15
Landscaping	10
Nurse Call System	10
Nursing Service Furniture	15
Parking Lot Striping	2
Paving – Concrete	15
Photocopier - Small	3
Railings - Handrails (interior)	15
Scale	10
Sofa	12
Table - Overbed	15
Telephone System	10
Ventilator/Respiratory	10
Washing Machine - Linen, Large	15
Work Station	10

APPENDIX E – Self-Insurance

Self-insurance means that the provider has chosen to assume the risk to protect itself against anticipated liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan, a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Such administrative costs are allowable costs that should be reported in ***Step 8f.***

There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance. Contributions to a special risk management fund or pool that is operated by a third party that assumes some of the risk and that has an annual actuarial review are allowable costs and are not considered self-insurance. Examples of such special risk management funds and pools include the Texas Council Risk Management Fund and the Texas Municipal League Intergovernmental Risk Pool.

- Allowable self-insurance costs for contracted providers include claims-paid (cash basis) costs, paid coinsurance provisions and deductibles and compensation paid to employees injured on the job where the contracted provider has received certificates of authority to self-insure from the Texas Workers' Compensation Commission.
- Contributions to the insurance fund or reserve that do not represent payments based on current liabilities and security deposits related to the Texas Workers Compensation Commission Certificate of Authority to Self-Insure are not allowable self-insurance costs.
- Self-insurance costs in excess of costs for similar, comparable coverage by purchased and/or commercial insurance premiums are subject to a cost ceiling. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in 1 TAC §355.105(b)(2)(B)(ix) of this title. Refer to 1 TAC §355.103(b)(13)(E).

Cost Ceilings

For employee-related self-insurance (health, dental, worker's comp, etc.), the ceilings are either

- Cost that would have been incurred if purchased through a commercial policy or
- Cost equal to 10% of payroll of employees eligible for coverage

For non-employee related self-insurance (vehicle, building, etc.), the ceiling is the cost that would have been incurred if purchased through a commercial policy.

The amount above the ceiling may be calculated and carried over to future periods in the following manner.
For the initial reporting period:

1. Sum the allowable purchased insurance costs and the paid self-insurance claims for the cost-reporting period.
2. Calculate the self-insurance cost ceiling for the reporting period.
3. Compare items 1 and 2. If item 1 exceeds item 2, the costs in excess of the ceiling may be carried forward and expensed in future cost-reporting periods.

For subsequent reporting periods:

1. Sum the allowable purchased insurance costs and the paid self-insurance claims for the cost-reporting period.
2. Calculate the self-insurance cost ceiling for the reporting period.
3. Compare items 1 and 2.
    a. If item 1 exceeds item 2, the costs in excess of the ceiling may be carried forward and expensed in future cost-reporting periods.
    b. If item 1 is less than item 2, add excess carry-forward amounts from previous reporting periods until the calculated cost ceiling is met.

Documentation Requirements

Maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

For employee-related self-insurance, obtain each fiscal year's documentation to establish what premium costs would have been, had commercial insurance for total coverage been purchased **OR** determine the ceiling based on 10% of the payroll for the employees eligible for receipt of the particular coverage/benefit.

For non-employee related self-insurance, document the cost that would have been incurred if item were fully insured. Documentation must include bids from two commercial carriers and documented bids must be obtained at least once every three years.

APPENDIX F – Importing Data Into STAIRS

For a smaller provider, the ability of STAIRS to maintain data from year to year will be a positive and time-saving process. It is also possible to import large quantities of asset data into STAIRS. To do so requires that the instructions to prepare a file for upload be followed exactly. If data to be imported is not correctly formatted, it will not import correctly and the system will be unable to utilize the data.

All instructions for importing depreciable assets are found in a Word document at the bottom right of every page in STAIRS. The document is titled "Asset Import Instructions".

APPENDIX G - Schedules D, E, and G

Schedule D1: Nursing Facility Building Lease Information

If you lease your nursing facility building, you must complete Schedule D1 and attach a copy of the lease agreement(s) in effect during your cost-reporting period. *A copy of the lease agreement must be attached to **each** year's accountability report and properly cross-referenced:* submission of the lease agreement with a prior year's accountability report does not exempt a facility from the requirement to submit a copy of the agreement with the current accountability report Schedules and attachments. The lease agreement must be signed by all interested parties and include all sections and attachments.

If the name of the leased facility as listed on the lease is different from the name of the facility as listed on the cover page of the automated accountability report, please provide a written explanation for the difference.

Item 1 (Type of Ownership of Lessor Entity): If the type of ownership of your lessor entity is not listed in item 1 (e.g., a trust), please indicate the type of ownership by writing it in.

Item 2 (Lessor Entity Identification): Complete all lines. Note that this year, we have added space for the name, title, and phone and fax number of a contact person with the lessor entity.

Item 3 (Related Party Information): If you check "Yes" on this item, you must complete Schedule B, Sections 1A and 3.

Item 4 (Lessor Entity Owners): Please note that this year, in addition to name and title, are required to provide the percent ownership for each individual with 5% or more ownership interest in the lessor entity. If the lessor ownership type is a trust, list each beneficiary of the trust with 5% or more interest in the trust.

NOTE: If indicated "Yes" on Step 8a (Was the nursing facility building leased during the cost-reporting period?) and/or reported a cost on Step 8f (Rent / Lease - Building and Building Equipment_Program Admin & Operations), you must complete Schedule D.

If two or more leases were in effect during your cost-reporting period, you must complete a separate Schedule D for each lease and provide a table showing the time period each lease was in effect.

Schedule D2: Central Office/Shared Administration Building Lease Information

See instructions above for Schedule D1. It is not required to submit with the accountability report Schedules and attachments a copy of the central office/shared administration building lease unless the lease is with a related party individual/organization. Central office leased building costs should be reported in Step 8f Rent / Lease - Building and Building Equipment_Central Office.

Schedule E: Contract Management Information

If the facility received contracted facility management services (as defined in the Definitions section of these instructions), Schedule E must be completed and a copy of the management agreement(s) in effect during your cost-reporting period must be uploaded to STAIRS. A *copy of the management agreement must be uploaded with each year's accountability report and properly cross-referenced: submission* of the agreement with a prior year's accountability report does not exempt a facility from the requirement to submit a copy of the management agreement with the current accountability report Schedules and attachments. The management agreement must be signed by all interested parties and include all sections and attachments. If there is no written management agreement, attach and cross-reference a written explanation as to why this is so.

Item 1 (Type of Ownership of Managing Entity): If the type of ownership of your managing entity is not a listed option in item 1 (e.g., a trust), please indicate the type of ownership by writing it in.

Item 2 (Managing Entity Identification): Complete all lines. Note that this year, we have added space for the name, title, and phone and fax number of a contact person with the managing entity.

Item 3 (Related Party Information): Indicate Yes or No.

Item 4 (Managing Entity Owners): Please note that this year, in addition to name and title, are required to provide the percent ownership for each individual with 5% or more ownership interest in the managing entity. If the managing entity ownership type is a trust, list each beneficiary of the trust with 5% or more interest in the trust.

NOTE: If the provider answered "Yes" to "Do you have any contracted management costs to report?" on Step 6a and/or reported a cost for "Fees - Management Contract" on Step 8f, the provider must complete Schedule E. The provider must complete Schedule E for both nonrelated party and related party management agreements. Related party management expenses must be reported at the cost to the related party as central office expenses, with the costs separately reported by cost category as applicable in Step 7 (Payroll Taxes) and Step 8f. Central Office costs may not be collapsed into a single item.

If two or more management agreements were in effect during your cost-reporting period, you must complete a separate Schedule E for each management agreement and provide a table showing the time period each agreement was in effect.

Schedule G: Ancillary Costs for Medicaid-Only Residents

NOTES:
The advent of the Medicare Prospective Payment System (PPS) for skilled nursing facilities should have no impact on how to complete Schedule G. *The Medicare Condition of Participation requiring nursing facilities to accrue charges for all residents (Medicare and non-Medicare) who receive ancillary services remains in effect. According to this requirement, ancillary charges must be based on a uniform charge structure and recorded at the same rate, for the same service, for all residents. Consequently, you should be able to properly complete Schedule G for your 2018 Texas Nursing Facility Accountability report in the same manner as instructed in previous years.*

For Medicaid cost-reporting purposes, only ancillary costs incurred for providing ancillary services to ***MEDICAID-ONLY*** residents that are not reimbursable through the DADS Specialized Services or Rehabilitative Services programs may be included on this accountability report. Costs incurred and revenues accrued for providing ancillary services to ***NON-MEDICAID*** residents are unallowable and ***MUST NOT*** be included on this accountability report. Ancillary services refer to services that are not routine. A charge separate from the routine "daily charge" for non-Medicaid residents is customarily or, historically, has been, made for ancillary services.

Schedule G is not intended to capture building or departmental equipment expenses. Ancillary building and departmental equipment expenses associated with entities other than the nursing facility should be removed from the accountability report through the use of appropriate allocation methods. Ancillary building and departmental equipment expenses associated with the nursing facility should be reported on the appropriate automated accountability report items.

Therapy services provided by staff of a nursing facility only to residents of that nursing facility (and not provided to persons outside the facility) are not considered a separate business component, but are considered non-routine nursing facility services. Therefore, shared facility-level costs that support the entire facility including therapy services, such as the administrator, facility office staff, and facility building and operational costs, and the related central-office costs, do not need to be allocated and removed from the accountability report. Other direct therapy-related expenses should be reported according to the instructions for Schedule G.

Therapy services provided from the central office, a separate division/unit of a company, or a related company separate from the nursing facility (which may or may not serve persons outside the facility), are considered a separate business component and those costs that cannot be directly charged to the nursing facility must be allocated based upon the total-cost-less-facility-cost method, the labor method, applicable time studies, or acceptable functional methods. Units of service is not an acceptable allocation method in this situation.

MEDICAID-ONLY RESIDENTS
"MEDICAID-ONLY residents" refers to residents who are eligible recipients of Medicaid Nursing Facility Vendor Payments and who ***ARE NOT ELIGIBLE*** for payments for Ancillary Services from other sources such as Medicare or Private Insurance.

NON-MEDICAID RESIDENTS

"NON-MEDICAID residents" refers to all residents other than Medicaid-only residents as defined above and includes, but is not limited to, Private, Private Insurance, Veterans Administration, Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB) and Dual Eligible (Medicare/Medicaid) residents.

SECTION 1 (ANCILLARY COSTS FOR MEDICAID-ONLY RESIDENTS) - COMPLETION INSTRUCTIONS

Providers Who DO NOT Participate In The Medicare Program

Providers who do not participate in the Medicare program are to complete Columns F and G only (leaving Columns B through E blank). Schedule G was designed based on Medicare Conditions of Participation that specify certain accounting/bookkeeping requirements; therefore, providers who do not participate in the Medicare program are unable to use Columns B through E to calculate their Medicaid ancillary costs. Non-Medicare providers must use reasonable methods to identify and calculate their costs incurred for providing ancillary services to Medicaid-Only residents.

Providers Who Participate In The Medicare Program

Providers who participate in the Medicare program will fall under one of two categories: (1) those whose accounting records separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents and (2) those whose accounting records do not.

Medicare Providers Who Maintain Separate Records

Medicare providers who maintain accounting records that separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents are to complete Columns F and G only (leaving Columns B through E blank) for each type of ancillary item that applies. See instructions for Columns F and G.

Medicare Providers Who DO NOT Maintain Separate Records

Medicare providers who do not maintain accounting records that separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents are to complete Columns B through G in order to calculate the portion of their ancillary costs attributable to Medicaid residents. Schedule G is designed based on the Medicare Condition of Participation that requires nursing facilities that participate in the Medicare program to accrue charges for all residents (Medicare and non-Medicare) who receive ancillary services. According to these requirements, ancillary charges must be based on a uniform charge structure and recorded at the same rate, for the same service, for all residents. Therefore, the costs of the ancillary services provided to different types of residents are proportionally related to the recorded revenues for those residents. Because of this Medicare requirement, the cost of Medicaid ancillary services can be calculated using the recorded Medicaid ancillary revenues.

COLUMN A (Ancillary Description) - Identify the type of ancillary service.

COLUMN B (Gross Ancillary Revenue For All Residents) - Enter the total amount of ancillary revenues accrued for ancillary services provided to all residents, both Medicaid-Only and non-Medicaid.

COLUMN C (Gross Ancillary Revenue For Medicaid Residents Only) - Enter the amount of ancillary revenue accrued for ancillary services provided to *MEDICAID-ONLY RESIDENTS.*

COLUMN D (Percent of Medicaid-Only Ancillary Revenue) - Calculate the percentage of Medicaid-Only ancillary revenue to total ancillary revenue by dividing the amount in Column C by the amount in Column B. Record this percentage in Column D (with a minimum of 2 decimal places).

COLUMN E (Ancillary Cost For All Residents) - Enter the total amount of ancillary cost for all residents, both Medicaid-Only and Non-Medicaid. **SUBTRACT** from this amount any reimbursements received from the DADS Specialized Services or Rehabilitative Services programs. Report net expenses, meaning gross expenses less any discounts, rebates, or allowances.

COLUMN F (Medicaid-Only Ancillary Cost) - If completing Columns B through E, calculate the amount of allowable Medicaid ancillary cost by multiplying the total ancillary cost in Column E by the Medicaid ancillary revenue percentage in Column D.

If completing Columns F and G only, enter in Column F the cost incurred for providing each applicable type of ancillary service to ***MEDICAID-ONLY RESIDENTS.*** **SUBTRACT** from this amount any reimbursements received from the DADS Specialized Services or Rehabilitative Services programs. Report net expenses, meaning gross expenses less any discounts, rebates, or allowances.

COLUMN G (Breakdown of Column F) - Column G identifies the accountability report item number(s) on which all Medicaid ancillary costs must be reported (item numbers other than those provided are not to be used for reporting these costs). Enter the cost from Column F under the item number(s) provided in Column G that most properly identifies the Medicaid ancillary cost incurred. If it is necessary to allocate costs between item numbers, attach (and properly cross-reference) documentation that identifies the method of allocation used and details how the allocation was made. In addition, indicate the type of allocation method(s) used in Step 6.d.

For each ancillary type, ensure that the sum of the amount(s) reported in Column G is equal to the corresponding Medicaid ancillary cost in Column F. For example, if your facility's direct ancillary cost for Medicaid-Only residents for physical therapy was $10,000 with $8,000 accrued for Ancillary Therapists' salaries and wages and $2,000 accrued for Therapy Supplies, then $10,000 would be entered in Column F, $8,000 under Step 6d Box 1 in Column G and $2,000 under Step 8f Box 3 in Column G.

Row 1 thru 4 Notes: Ancillary Therapist, Contracted, Assistant, and Contracted Assistant Therapy costs include (1) salaries and wages for (a) Physical Therapists or Physical Therapy Assistants licensed by the Texas State Board of Physical Therapy Examiners (b) Occupational Therapists or Occupational Therapy Assistants licensed by the Texas State Board of Occupational Therapy Examiners, (c) Speech Therapists (Pathologists) licensed by the Texas State Board of Examiners of Speech-Language Pathology and Audiology, (d) Respiratory Therapists (inhalation therapist) licensed by the Department of State Health Services Respiratory Care Practitioners Program, (e) Intravenous Therapy (the injection of fluids directly into veins), and (f) Air Fluidized Therapy (costs associated with are-fluidized therapy beds.

Row 5 Notes: Other Ancillary Therapy costs include therapy costs other than those indicated above.

Row 6 Notes: Contract Other Ancillary Staff costs include those types provided in Row 5 above but by Contracted personnel.

Row 7 Notes: Costs for Therapy Supplies should be reported here.

Row 8 Notes: Physical Therapy costs include (1) salaries and wages for physical therapists licensed as physical therapists by the Texas State Board of Physical Therapy Examiners and physical therapy assistants licensed as physical therapy assistants by the Texas State Board of Physical Therapy Examiners and (2) the cost of physical therapy supplies, physical therapy consultants and contract and off-site physical therapy.

Occupational Therapy costs include (1) salaries and wages for occupational therapists licensed by the Texas Board of Occupational Therapy Examiners and occupational therapy assistants licensed by the Texas State Board of Occupational Therapy Examiners and (2) the cost of occupational therapy supplies, occupational therapy consultants and contract and off-site occupational therapy.

Speech Therapy costs include (1) salaries and wages for speech-language pathologists who are Texas licensed speech-language pathologists or who meet the educational requirements for license and have accumulated, or are in the process of accumulating, the supervised professional experience (the internship) required for license and audiologists who are Texas licensed audiologists or who meet the educational requirements for license and have accumulated, or are in the process of accumulating, the supervised professional experience (the internship required for license) and (2) the cost of speech therapy supplies, speech therapy consultants and contract and off-site speech therapy.

Row 9 Notes: Report the costs for Contracted and Off-Site Therapy (those not included in Rows 2, 4, or 6) on this row.

Row 10 Notes: Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent
Nutritional Therapy (Excluding Food Supplies) includes supplies and specialized staff costs related to the delivery of parenteral and enteral nutrition. Do not include the cost of the actual parenteral or enteral nutrition in this row; those costs should be reported in Row 16. The delivery of Ensure and other similar products enterally (e.g., through a feeding tube) is not considered an ancillary service and the cost of supplies related to the delivery of such products should be reported in Step 8f (Supplies: Nursing and Medical)**.**

Nutritional Therapy Food Supplies includes the costs of parenteral and enteral nutritional products. Do not include the costs of and specialized staff related to the delivery of these products to the resident; those costs should be reported in Row 10. Ensure and similar products are not considered ancillary products and the costs of Ensure, etc., should be reported as food costs in Step 8f Contract Dietary Services.

Chargeable Medical and Nursing Supplies include such items as surgical dressings, and splints, casts and other devices used for the reduction of fractures and dislocations, prosthetic devices (other than dental and devices related to incontinence) which replace all or part of an internal body organ, leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes. *Medical and nursing supplies* (such as tongue depressors, swabs, Band-Aids, cotton balls, alcohol, and incontinent supplies) which are routinely provided to Medicaid and non-Medicaid residents and *are not chargeable* (or

considered) as ancillaries to Medicare or other non-Medicaid sources are not to be included in this section. Because these supplies are considered routine items, treat these supply costs as routine by adding them to the medical and nursing supplies costs in Step 8f. The associated charges, if any, made to non-Medicaid residents would be added to the routine daily revenues reported on page 5 in the appropriate resident category.

Chargeable Incontinent Supplies include urinary collection and retention systems including Foley catheters when ordered for a resident with permanent urinary incontinence as well as colostomy bags and necessary accoutrements required for attachment and other supplies directly related to ostomy care. Do not include chucks, diapers, rubber sheets, etc. Urinary collection and retention systems that are not for residents with permanent urinary incontinence should be reported as "Supplies - Nursing and Medical" in Step 8f.

Row 12 Notes: Diagnostic Laboratory and Radiology
Diagnostic X-ray tests provided by the NF if the NF has a radiological department that meets the same standards required of a hospital under Medicare or if the NF meets the portable X-ray supplier standards under Medicare are to be reported on Schedule G, Row 8. Laboratory services if the NF has a valid Clinical Laboratory Improvement Act (CLIA) certificate that covers the types of testing performed by the NF are to be reported on Schedule G, Row 8. X-ray, Radium and Radioactive Isotope Therapy provided by the NF if the NF has a radiological department that meets the same standards required of a hospital under Medicare are to be reported on Schedule G, Row 8. Personnel costs related to these items are to be transferred from Column G to Step 6d Box 1 while other related costs are to be transferred from Column G to Step 8f Box 9.

Row 13 Notes: Drugs and Pharmaceuticals
Chargeable Drugs and Pharmaceuticals include drugs included or approved for inclusion in the U.S. Pharmacopoeia, the National Formulary, or the U.S. Homeopathic Pharmacopoeia or, except for those unfavorably evaluated, in AMA Drug Evaluations. Also included are hemophilia clotting factors and other blood products. None of these items should have been paid for through the Medicaid vendor drug program or any other payment source if they are reported as Medicaid-only costs on Schedule G.

Row 14 Notes: Oxygen
Chargeable Oxygen includes oxygen therapy where the need and effectiveness is documented, where there is a physician's order stating the oxygen device and/or the specific flow rate or concentration of oxygen required and where periodic assessment of arterial PO2 or oxygen saturation is performed. Oxygen delivered "PRN" or "as needed" does not meet these requirements and should be reported as " Resident Care: Supplies_Program Admin & Operations" in Step 8f. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy. Non-depreciable equipment associated with the delivery of oxygen must be reported under routine medical supplies in Step 8f. Effective for purchases made on or after the beginning date of the provider's 2004 fiscal year, non-depreciable equipment is equipment that cost less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that cost $5,000 or more and has a useful life of more than one year. As well, purchases made before the provider's 2004 fiscal year that cost more than $1,000 and have a useful life of more than one year must be depreciated using the straight line method. For all contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 2015, an asset valued at $5,000 or more and with an

estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than the capitalization level for that fiscal period as described above or having a useful life of one year or less. If the equipment meets the definition of DME, the depreciation costs should be reported in Step 8f.

Row 15 Notes: DME Purchased by Provider
Chargeable DME and Equipment Rental includes medical equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the resident's place of residence (i.e., the NF). Do not include depreciable DME. Depreciable DME should be reported on Schedule A, Part 4 and transferred to Step 8f. General use wheelchairs and hospital beds not prescribed by a physician are not considered DME and should not be depreciated as departmental equipment (Step 8f)

Row 16 Notes: DME Rental/Lease Expense
Chargeable DME and Equipment Rental includes medical equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the resident's place of residence (i.e., the NF). Do not include depreciable DME. Depreciable DME should be reported on Schedule A, Part 4 and transferred to Step 8f. General use wheelchairs and hospital beds not prescribed by a physician are not considered DME and should not be depreciated as departmental equipment (Step 8f)

SECTION 2 (ANCILLARY DIRECT-CARE STAFF PAID HOURS FOR MEDICAID-ONLY RESIDENTS) - COMPLETION INSTRUCTIONS

For Medicaid cost-reporting purposes, only ancillary direct-care staff paid hours spent providing ancillary services to ***MEDICAID-ONLY*** residents may be included on this automated accountability report

Using Section 2 of Schedule G, for each staff type (i.e., Ancillary Therapists, Ancillary Therapy Assistants, and Other Ancillary Staff) for each type of therapy (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.,) perform the following steps:

1. Determine the total paid hours by staff type and therapy type and enter the value in the applicable Column A;
2. Determine the percent Medicaid-only revenue applicable to the type of therapy from Schedule G, Section 1, Column D and enter the value in the applicable Column B.
3. Multiply the value in Column A by the value in Column B and enter the product in Column C.
4. In Row 7, for each staff type, sum the values in Column C. The sum values in Row 7, Column C are the Medicaid-only paid hours to be reported on the accountability report for each staff type (i.e., Step 6d for Ancillary Therapists' hours, Step 6d for Ancillary Therapy Assistants' hours, and Step 6d for Other Ancillary Staff hours).

SECTION 3 (ANCILLARY INDIRECT COSTS FOR MEDICAID-ONLY RESIDENTS) - COMPLETION INSTRUCTIONS

Ancillary indirect expenses are central office expenses (i.e., shared administrative expenses) related to the provision of ancillary services. For Medicaid cost-reporting purposes, only appropriately allocated ancillary indirect expenses related to the provision of ancillary services for **MEDICAID-ONLY** residents may be included on this accountability report. Ancillary administrative costs at the facility level are not to be reported on Schedule G; rather they should be reported in the appropriate items in the Administration Costs section of the accountability report.

For each type of Ancillary Indirect cost (i.e., salaries and wages, payroll taxes and workers' compensation, employee benefits and contracted supervision), enter the ancillary indirect expense in column B, the total direct ancillary cost for all residents (from Schedule G, Section 1, Row 17, Column E) in Column C and the total direct ancillary cost for Medicaid-only residents (from Schedule G, Section 1, Row 17, Column F) in Column D. Divide the value in Column D by the value in Column C and multiply the result by the value in Column B, enter the product in Column E. The values in Column E are the Indirect Ancillary Costs for Medicaid-only residents to be reported in Step 7 and Step 8f.